MEDICAID ESTATE PLANNING IN THE AFTERMATH OF OBRA '93

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1.0 INTRODUCTION

1.1 What is Medicaid Estate Planning?

Medicaid is a medical assistance program targeted to people who are poor. It is a "means-tested" program, meaning that in order to qualify for Medicaid benefits, applicants must have incomes and/or resources below certain financial criteria. The means-testing of Medicaid benefits is done to ensure that public resources are being used to provide medical assistance to people who cannot afford to provide for their own health care.

"Medicaid estate planning" is a term used to describe a process by which elderly persons *purposefully* divest their assets and/or income in order to qualify for Medicaid benefits, particularly coverage for nursing home care. The goal of Medicaid estate planning is to preserve assets for family and heirs, rather than depleting one's assets on the private cost of nursing home care. Since private nursing home costs typically average over $3,000 per month, an individual who pays privately for his or her nursing home care, and does *not* do Medicaid estate planning, can easily deplete their entire life savings during an extended nursing home stay.

Medicaid estate planning has several variations. For married couples, Medicaid estate planning usually has the objective of ensuring that the spouse remaining in the community (the "non-institutionalized spouse") retains as much of the married couple's combined income and resources as possible, so that he or she can continue to live the same lifestyle as prior to the admission of the institutionalized spouse. Another objective is to ensure that the community spouse will remain financially secure after the institutionalized spouse dies. For single persons, the goal of Medicaid estate planning is generally to preserve inheritances for heirs, usually the nursing home resident's children. A third goal of Medicaid estate planning involves protecting estates (largely the family home) from recovery efforts by state Medicaid programs acting as creditors against a deceased Medicaid recipient's estate.

It is important to recognize that although many people think Medicaid estate planning is *unethical*, it is not *illegal*. The rules which determine whether individuals applying for Medicaid coverage meet the program's financial eligibility criteria are complex, and these rules provide opportunities for savvy individuals to divest or shelter their assets without penalty. And because the rules are complex, individuals who participate in Medicaid estate planning often seek the counsel of people who have special expertise in these matters, generally elder law attorneys. Indeed, over the last

decade, "elder law" has been a rapidly growing specialty in the legal profession, and within the practice of elder law, Medicaid estate planning represents a significant proportion of the business conducted.

1.2 Objectives of the Study

This study represents the third in a series of studies on Medicaid estate planning and public policy responses to Medicaid estate planning.[1] The study was sponsored by the Office of Research and Demonstrations at the Health Care Financing Administration through a contract with Lewin-VHI, and a subcontract to The MEDSTAT Group. The objectives of the study were as follows:

- To assess the magnitude of Medicaid estate planning in selected states;
- To identify the most commonly used Medicaid estate planning techniques in the selected states, and variation in the use of techniques across states;
- To assess relationships between Medicaid estate planning activities and (1) state Medicaid eligibility policies; and (2) state administrative practices in the eligibility determination process;
- To assess the impacts of legislative changes enacted under the Omnibus Budget Reconciliation Act of 1993 on Medicaid estate planning;[2] and
- To assess the feasibility of conducting more empirical research that could measure the magnitude of Medicaid estate planning activity and/or effects of public policy responses.

1.3 Study Methodology

A case study methodology was employed, and four states were selected to participate in the study. The four states were Massachusetts, California, New York and Florida. The selection of the four case study states was not random. New York and California were selected because they represent the two largest Medicaid programs in the country. They were also selected for their contrast: New York has among the highest per capita Medicaid nursing home expenditures in the country, while California is among the lowest spending states per capita. New York and Massachusetts were also selected based upon the general knowledge that the Medicaid planning "industry" had grown rapidly in these two states, relative to other states. Florida was selected because it is an "income cap" state, which has a definite relationship to Medicaid estate planning techniques. The states' willingness to

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[1]See Burwell, B. **Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage**. SysteMetrics, Lexington, MA, September 1991; and Burwell, B. **State Responses to Medicaid Estate Planning**, SysteMetrics/MEDSTAT, Cambridge, MA, May 1993.

[2]For a discussion of the specific provisions of OBRA 1993 related to Medicaid estate planning, see Section 1.4.

participate in the study, and to cooperate with the demands of the site visits, was also a factor in their selection.

Table 1 provides background information on the four states selected for the case studies. Three of the four states—California, New York, and Massachusetts—extend nursing home coverage to the medically needy—while Florida only covers individuals whose countable income falls below a special "income cap" equal to 300% of the Federal SSI benefit level. In 1994, the income cap in Florida was $1,338 per month. All four states had estate recovery programs in operation *prior to* OBRA '93, although Florida's program was minimal, and did not seek recoveries from real property. Two states—California and Massachusetts—operated estate recovery programs on a centralized basis, meaning that all recoveries were conducted by a single state agency. In New York, the responsibility for estate recoveries was delegated to each individual county. New York and Massachusetts used TEFRA liens as part of their estate recovery programs. California had recently enacted legislation for a lien program, but had not yet implemented it. Florida did not use TEFRA liens prior to the enactment of OBRA '93, but was considering doing so.

California, Florida, and New York set the Community Spouse Resource Allowance (CSRA) level at the maximum allowed under Federal law, which was $72,660 in 1994, while in Massachusetts, the CSRA level was set at the minimum amount allowed—$14,532. New York and California set the Minimum Monthly Maintenance Needs Allowance (MMMNA) at the maximum, which was $1,817 in 1994. Florida and Massachusetts had set the MMMNA at the floor of $1,179, although this amount could be increased for excess shelter expenses.

Two of the four states rank very high among the 50 states in regard to the amount they spend for nursing home care under the Medicaid program. Except for Connecticut, New York spends more for Medicaid-covered nursing home care per elderly state resident than any other state, and Massachusetts ranks fifth among the states on this measure. Florida and California, on the other hand, spend far less than the national average on Medicaid-financed nursing home care, ranking 49th and 35th respectively.

The primary data collection approach used in the study was a one-week site visit to each state by a two-person site visit team. Generally, on the first day of the site visit, the team met with state Medicaid eligibility staff to discuss long-term care eligibility policies, perceptions about the magnitude of Medicaid estate planning activity, and state policy responses to Medicaid estate planning. Also, the team met with staff from each state's Estate Recovery Program to discuss the organizational and

administrative structure of Medicaid estate recovery, recent developments in estate recovery efforts, and state implementation of OBRA 1993 mandates related to estate recovery.

The remaining four days of the site visit concentrated on the conduct of interviews with front-line Medicaid eligibility workers and supervisors in local eligibility offices. These interviews were usually set up by state Medicaid eligibility staff. The selection of local offices to visit was not random. Usually, state Medicaid staff selected counties where they felt significant Medicaid planning activity was occurring, or where the local office had undertaken a specific response to the problem. In Massachusetts, however, there are only three eligibility offices in the entire state that process applications for long-term care coverage and all three were visited.

The interview protocol with local eligibility workers and their supervisors was relatively unstructured, but touched upon common themes. Workers were asked specific questions about their interpretation of current policy regarding how various assets are treated in the application process. Examples of the types of questions that were asked of workers and supervisors are as follows:

1. What is the policy regarding the treatment of the home for married applicants, for single applicants? What if the home has been transferred prior to the date of application? What is your policy regarding second homes? Do you do any independent property checks to identify properties that may not be reported on the application?

2. How do you evaluate assets held in savings accounts? What is your policy regarding applying transfer of asset penalties when assets in saving accounts have been withdrawn prior to application? How do you treat joint bank accounts? Do you do any independent checking to identify additional accounts that may not be reported on the application?

3. What happens when applicants report the existence of trust instruments, or annuities? Do front-line workers assess whether these assets are exempt, or are these decisions referred to specialists, such as a legal counsel?

4. What are your current policies regarding the exemption of other assets, such as automobiles, household goods, art or jewelry, business property, burial contracts, etc.?

5. What is your perception of the level of Medicaid estate planning in this area? What percentage of applicants do you believe have done something prior to submitting an application to divert or shelter assets? How often are applications prepared by attorneys rather than the applicants themselves? What are the most common Medicaid planning techniques you encounter in processing applications? How has the level of Medicaid estate planning activity changed over the time of your employment in this office?

6. Have you encountered planning techniques to increase the Community Spouse Resource Allowance (CSRA) above the maximums allowed under the Medicaid spousal impoverishment provisions? If so, what techniques are used? Have applicants used the fair hearing process to increase the CSRA for the community spouse? If so, how does this work? What have been the outcomes of these fair hearings?

Table 1
Selected Characteristics of Case Study States

	Income Cap State[3]	Had Estate Recovery Program Prior to OBRA '93	Centralized Estate Recovery	Uses TEFRA Liens[4]	1994 CSRA[5] Minimum	1994 MMMNA[6] Maximum	Medicaid Nursing Home Expenditures per Elderly State Resident, 1992[7] (State rank)
California	No	Yes	Yes	No	$72,660	$1,817	$474 (35)
Florida	Yes	Yes, but minimal	No	No	$72,660	$1,179	$302 (49)
Massachusetts	No	Yes	Yes	Yes	$14,532	$1,179	$1,185 (5)
New York	No	Yes	No	Yes, at county discretion	$72,660	$1,817	$1,353 (2)

[3]An income cap state is one which does not provide nursing home coverage to "medically needy" Medicaid applicants, but only to persons whose countable incomes fall below a special income level, which under Federal law cannot exceed 300% of the Federal SSI benefit level.

[4]TEFRA liens are imposed on real property (usually the home) of Medicaid recipients to and protect the interests of the state in recovering incurred Medicaid costs from the property upon the sale of the home or upon the death of the Medicaid recipient.

[5]The CSRA is the Community Spouse Resource Allowance, the amount of assets retained by a non-institutionalized spouse of a Medicaid applicant, and is excluded in determining eligibility for the institutionalized spouse.

[6]The MMMNA is the Minimum Monthly Maintenance Needs Allowance, which is the amount of *protected* income allowed for the non-institutionalized spouse. All remaining countable income of the Medicaid recipient excluding a personal needs allowance, must be used as the Medicaid recipient's contribution to his or her nursing home care. It is important to note that unlike the treatment of *assets*, in which a married couple's total combined assets are considered available to the Medicaid applicant, Medicaid eligibility rules treat a couple's *income* separately. Thus, if the non-institutionalized spouse has independent income in *excess* of the MMMNA, he or she is *not* required to contribute to the cost of the institutionalized spouse's nursing home care beyond the first month of institutionalization.

[7]Mean Medicaid expenditures per elderly resident nationwide were $623 in 1992.

In addition to local Medicaid eligibility staff, interviews were conducted with other individuals who play a role in Medicaid estate planning activity. In all four states, we interviewed Medicaid estate planning attorneys to elicit their perspectives on the size and growth of the Medicaid estate planning industry, the demand for their services, and state policy responses to the growth of Medicaid estate planning. In addition, we sometimes interviewed nursing home administrators and representatives of state nursing home associations. In the state of New York, we also conducted interviews with the state Department on Aging, which provides counseling to seniors on long-term care planning issues.

It is important to underscore the limitations of the findings reported in this study. First, in addressing the objectives of the study identified on page two, the findings reported are qualitative, not quantitative, in nature. The "data" presented in the study are largely the reports and observations of the people that we interviewed during the course of the study. These data are obviously subject to personal bias.

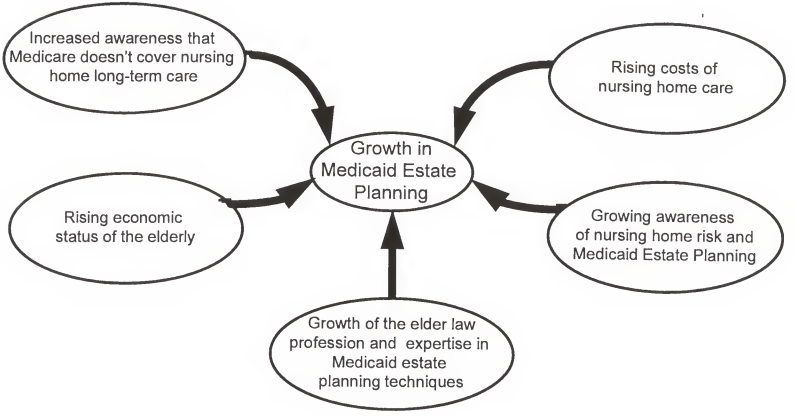
Second, we purposefully selected states and counties within states where the level of Medicaid estate planning was expected to be relatively high. Thus, the reported of magnitude of Medicaid estate planning activity in the states and counties selected for the study is probably higher than that which would have been reported if we had randomly selected states and counties to visit. As discussed later on, higher levels of Medicaid planning were reported in more wealthy geographical areas, and if we had selected Kansas, Iowa, Texas, and Kentucky as the case study states, rather than New York, California, Massachusetts, and Florida, reported Medicaid estate planning activity would have undoubtedly been lower.

1.4 Why Medicaid Estate Planning is Growing

A number of factors are contributing to the growth in Medicaid estate planning (See Figure 1). First, older individuals are becoming increasingly aware that nursing home care is not covered by Medicare. The debate surrounding the repeal of the Medicare Catastrophic Coverage Act of 1988 played an important role in this growing awareness, as did discussions of the need for public long-term care insurance in the recent Congressional debate regarding President Clinton's Health Security Act.

Second, the complexity of the "spousal impoverishment" provisions of the Medicare Catastrophic Coverage Care Act, in combination with the rising economic status of the older population, has spurred many older persons to seek professional advice in planning for long-term care. Table 2 shows that median net worth (in constant dollars) for persons age 65 and over has *increased* quite

Figure 1
Why the Practice of Medicaid Estate Planning May be Growing


Increased awareness that Medicare doesn't cover nursing home long-term care
Rising costs of nursing home care
Growth in Medicaid Estate Planning
Rising economic status of the elderly
Growing awareness of nursing home risk and Medicaid Estate Planning
Growth of the elder law profession and expertise in Medicaid estate planning techniques

significantly in recent years.[8] Thus, elderly persons at risk of needing long-term care have increased incentives to protect their wealth from the catastrophic costs of long-term care services, particularly nursing home care. The table also shows, however, that most of the net worth among the elderly is concentrated in home equity. Excluding home equity, the median asset level of older households would finance less than a year of nursing home care in most locations.

Table 2

Trends in Median Household Net Worth

by Age of Household Head

(1991 Constant Dollars)

Age	1984	1988	1991
65 to 69			
Total Net Worth	$88,151	$96,834	$104,354
Excluding Home Equity	28,718	31,879	33,345
70 to 74			
Total Net Worth	79,476	95,249	92,793
Excluding Home Equity	24,732	32,679	25,943
75 and over			
Total Net Worth	72,920	71,330	76,541
Excluding Home Equity	22,584	21,830	22,866
65 and over			
Total Net Work	79,576	85,226	88,192
Excluding Home Equity	25,006	27,673	26,442

Sources: Eller, T.J. 1994. "Household Wealth and Asset Ownership: 1991." *Current Population Reports* P-20-34. Washington, D.C.: U.S. Bureau of the Census.

Eargle, J. 1990. "Household Wealth and Asset Ownership: 1988." *Current Population Reports* P-70-22. Washington, D.C.: U.S. Bureau of the Census

Third, the increased demand for Medicaid estate planning services has been met with increased supply. One indicator of supply, the membership level of the National Association of Elder Law

[8]In contrast, median net-worth for non-elderly households has declined.

Attorneys (NAELA), increased from 80 members in 1987 (the year NAELA was founded) to about 3,000 in 1994. It is not only the number of elder law attorneys that has been growing, but also the level of expertise among Medicaid Estate Planning attorneys. This expertise is routinely shared through conferences and newsletters that keep elder law attorneys abreast of the latest developments in the field.[9]

Fourth, the cost of a nursing home stay continues to rise every year. Currently, the private pay rate for nursing home care averages $3,000 to $4,000 per month, and is substantially higher in some areas (e.g., it is $5,000 to $6,000 per month on Long Island). Consequently, not only do the elderly have more wealth to protect, but the risk of losing their wealth from the high costs of private nursing home care has also increased.

Finally, recent research has highlighted the substantial lifetime risk of a nursing home stay.[10] Although, at any one time, only about 5 percent of the population age 65 and over is in a nursing home, estimates of the lifetime risk of institutionalization exceed 40 percent.

In short, the confluence of the rising economic status of the elderly, the rising costs of nursing home care, and the considerable lifetime risk of needing nursing home care has raised the financial consequences associated with needing long-term care. It is reasonable to expect that this growing risk, in combination with the shrinking numbers of elderly who mistakenly think that Medicare covers long-term care, and the growth in the elder law industry itself, would lead to growth in the practice of Medicaid estate planning.

1.5 Prior Research on Medicaid Estate Planning

The policy debate surrounding Medicaid estate planning is full of rhetoric and strong emotions but lacking in good information. Heated arguments frequently occur on the prevalence of Medicaid estate planning activity, as well as on its ethics. Some believe that Medicaid estate planning is a major policy problem in the Medicaid program, and that many elderly individuals who qualify for Medicaid coverage in nursing homes retain or divest significant assets that could be used to pay for their care

[9]A good example of such a newsletter is The ElderLaw Report published by Little, Brown and Company, Law Division, 34 Beacon Street, Boston, MA 02108.

[10]See, for example, P. Kemper and C. Murtaugh, 1991. "Lifetime Use of Nursing Home Care." New England Journal of Medicine. Vol. 342 (9): 595-600.

privately.[11] Others argue that the vast majority of disabled elderly persons have no or few financial assets to begin with and thus concerns over the magnitude of Medicaid estate planning as a policy problem are vastly overblown.[12] The polemics over Medicaid estate planning are also often made in the context of the "unfairness" of public policy regarding the lack of public insurance for nursing home care and the "draconian" nature of Medicaid's means-tested benefits.[13]

The methods of Medicaid estate planning are very complicated and not very amenable to quantitative measurement. Thus, empirical studies of Medicaid estate planning activity are few. In October 1992, the General Accounting Office conducted a review of 403 applications for Medicaid long-term care coverage in one of Massachusetts' three long-term care eligibility offices. The purpose of the review was to identify assets that had either been *converted* from countable assets to excluded assets or *transferred*. GAO found that more than half the applicants had converted assets, although the vast majority of these cases involved applicants setting aside funds in burial accounts that are excluded in determining Medicaid eligibility. In about 10 percent of the cases, applicants had transferred assets in the 30 month period prior to making application. The average amount of the transfer was about $46,000.[14]

1.6 OBRA '93: The Latest Federal Response to Medicaid Estate Planning

Medicaid estate planning has been a policy issue for many years in the Medicaid program, and Congress has taken a number of policy responses to restrict its practice. In 1980, Congress enacted the first provisions to deny Medicaid eligibility to persons who purposefully transferred assets in order to obtain Medicaid coverage. In 1982, transfer of asset restrictions were expanded to encompass certain excluded assets, such as the home. The Medicare Catastrophic Coverage Act (MCCA) of 1988 made a number of further amendments to the Medicaid transfer of asset rules, including requiring *all* states to adopt transfer of asset restrictions, rather than having these restrictions be optional.

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[11]See, for example, Moses, Steven: **The Magic Bullet: How to Pay for Universal Long-Term Care. A Case Study of Illinois.** LTC Incorporated, February 1995.

[12]See, for example, Weiner, Joshua; Hanley, Raymond; and Harris, Katherine: **The Economic Status of Elderly Nursing Home Users.** Unpublished manuscript, January 1994. Also, Sloan, F. and Shayne, M.: "Long-Term Care, Medicaid, and Impoverishment of the Elderly." **Milbank Quarterly** Volume 71, Number 4: 575-600, 1993.

[13]See, for example, **Medicaid Estate Recovery under OBRA '93: Picking the Bones of the Poor?** A Report by the Commission on Legal Problems of the Elderly. The American Bar Association, Washington, D.C., November 1994.

[14]General Accounting Office. **Medicaid Estate Planning.** GAO/HRD-93-29R.

On August 10, 1993, Congress enacted the Omnibus Budget Reconciliation Act (OBRA) of 1993, which included a number of changes to the Medicaid statute that were intended to address the growth of Medicaid estate planning. One objective of this study was to assess what impact OBRA '93 is likely to have on Medicaid estate planning, to describe how states are implementing the provisions of OBRA '93, and to elicit from the states their perspectives on further changes that are needed to address asset transfers.

Specific provisions enacted in OBRA '93 include:

- The "look-back" period for asset transfers was extended from 30 months to 36 months. The "look-back" period defines the period prior to Medicaid application in which asset transfers may be subject to a penalty period. Transfers made prior to the look-back period are not subject to penalty.

- The cap on the asset transfer penalty period was eliminated.[15] Previously, the asset transfer penalty period was subject to a 30-month cap. Under OBRA '93, there is no cap on the penalty, so that if someone transfers a very large amount of assets, the penalty period may extend for many years.

- Multiple transfers over a period of time are now treated as a single transfer. Prior to OBRA '93, some applicants and their attorneys were gaming the system by making multiple transfers of assets over a period of months, and then arguing that each transfer had to be treated as a separate transfer subject to its own penalty period. By having penalty periods run concurrently, applicants could greatly reduce the amount of time they had to wait between transferring their assets and becoming eligible for Medicaid. OBRA '93 clarified that penalty periods for multiple transfers are to run *consecutively* rather than *concurrently*.

- Transfers of jointly held assets are considered prohibited transfers subject to a penalty period. This provision clarified that when transfers are made from joint accounts that reduce the applicant's control or ownership of the asset, then the transfer will be subject to a penalty period. Prior to OBRA '93, some states did not treat withdrawals from joint accounts by *non-applicants* as prohibited transfers because the applicant himself had not made the transfer.

- Transfers made by applicants and recipients of non-institutional long-term care services are also subject to penalty, at the option of the state. Under this provision, states may, but are not required, to impose transfer of asset penalties on persons who have applied for or who are presently receiving non-institutional long-term care services.

- The circumstances under which income and assets placed in trusts are considered countable resources, and the circumstances under which assets transferred into a trust are considered an illegal transfers, were clarified. OBRA '93 includes rather lengthy clarifications of how assets transferred by the applicant, the applicant's spouse, or someone acting on behalf of the applicant, into a trust are to be treated in the Medicaid eligibility process. In most circumstances, the entire corpus of a trust is considered a countable asset. If not, the transfer of assets into the trust is subject to a penalty period with a 60-month look-back period. Thus,

[15]The "penalty period" is the length of time an applicant who would otherwise be Medicaid eligible is *denied* eligibility because he or she transferred assets prior to application.

transfers into a trust (because they are more likely to have occurred for Medicaid planning purposes) are treated more severely than other types of transfers.

- Certain kinds of trusts for disabled persons under age 65 are exempted from transfer of asset penalties. Most trusts created for the benefit of disabled persons under age 65 are not counted in the Medicaid eligibility process, and distributions from these kinds of trusts can be used to purchase supplemental services, equipment, etc. for disabled Medicaid recipients without affecting their Medicaid eligibility.

- Trusts established only with the income of applicants in so-called "income cap" states are not considered an available resource. This provision enables individuals who are denied Medicaid eligibility because they have incomes over Medicaid eligibility limits in so-called "income cap" states to attain Medicaid eligibility by temporarily transferring their income into an "income trust." Unlike the other provisions of OBRA '93, this provision *expands* Medicaid eligibility to certain individuals who would otherwise not be able to obtain Medicaid coverage for nursing home care in the 15 states that use income caps.[16]

- The law requires states to specify procedures and policies for administering hardship rules. Hardship rules specify the circumstances under which states will waive transfer of asset penalties, trust rules, and estate recovery rules in cases where the application of these provisions would cause "undue hardship" on the applicant, recipient, and/or surviving family members.

- All states are required to implement estate recovery programs. Prior to OBRA '93, only about half the states operated programs seeking to recover Medicaid nursing home costs from recipients' estates upon their deaths. In addition, OBRA '93 allows states to expand the definition of "estate" to include resources that pass to heirs outside the probate process, such as through joint tenancy, tenancy in common, rights of survivorship, life estates, living trusts, and other arrangements. By so expanding the definition of "estate", OBRA '93 expanded the scope of assets that could be subject to state recovery efforts.

[16]These 15 states are Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Idaho, Iowa, Mississippi, Nevada, New Jersey, New Mexico, South Dakota, and Wyoming.

2.0 FINDINGS

2.1 Magnitude of Medicaid Estate Planning in the Case Study States

We made no effort to measure the magnitude of Medicaid estate planning in the case study states, other than asking eligibility workers their personal opinions about the extent to which they believed applicants had participated in Medicaid estate planning activities prior to submitting their Medicaid applications. Readers must recognize that statements made here about the magnitude of Medicaid estate planning are primarily based upon the subjective opinions of the individuals we interviewed during the course of our site visits, as well as the authors' own personal observations.

Although there was clear evidence of Medicaid estate planning activity in all four states, it is fair to say that the majority of people who apply for Medicaid long-term care benefits have not purposefully divested or sheltered their assets prior to applying for Medicaid. Other than perhaps a home, a car, and some personal property, all of which are exempt in determining eligibility for Medicaid, *most* elderly people in need of nursing home care do not have a lot of financial assets. This is particularly true for persons without a living spouse. These individuals are also the least likely to know about the opportunities which Medicaid estate planning offers. People with low levels of assets also tend not to use financial planners, lawyers, or other financial experts.

It is also important to point out that for people with few financial assets (e.g., less than $20,000), the question of whether they do "Medicaid estate planning" is often a fuzzy one. For example, a daughter may make a Medicaid application for her elderly mother who needs nursing home care, and who has $15,000 in savings but nothing else. The application may be denied because the applicant has "excess resources."[17] In the course of the application, the eligibility worker may educate the daughter about legitimate strategies to dispose of excess resources. The worker may simply advise the daughter to spend the money on other things her mother may need. Does the house need a new roof or other major repairs? Are there any loans to pay off? Does the car need a major check up? Does your mother need a new refrigerator or other household items? The daughter may go back home and spend the $15,000 in the bank on various "needed" purchases, then reapply for Medicaid for her mother the following month and be determined eligible.

Does this spending of excess resources constitute Medicaid estate planning? We tend to think not. Rather, our conceptualization of Medicaid estate planning is more on the level of planned and

[17]In most states, the asset level for Medicaid eligibility for a single individual is $2,000.

purposeful activity by people with *significant* levels of assets to avoid paying privately for their nursing home care.

Medicaid estate planning is also distinguished from simple *estate* planning. Estate planning generally involves strategies to reduce assets in order to avoid Federal and state taxation of estates upon death. Under Federal law, the first $600,000 in assets is exempt from Federal estate tax, so that estate planning for Federal tax purposes is not a concern for individuals with net worths of less than $600,000. State estate taxes vary from state to state, with some states having no estate taxes at all. However, it is important to recognize that many elderly individuals transfer assets simply as part of regular estate planning, not for the purposes of qualifying for Medicaid. Indeed, Medicaid estate planning can be viewed as a subset of general estate planning, and most attorneys who do Medicaid planning do it as part of a larger estate planning practice.

In all four states, we found clear evidence of *Medicaid* estate planning activity. However, the level of activity was not uniform across the four states, nor was it even uniform within individual states. In some counties, eligibility workers would report a high level of Medicaid estate planning activity. In other counties, workers would report very little activity.

In general, there was a strong relationship between the level of Medicaid estate planning reported by local eligibility offices and the level of financial wealth within a geographical area. The higher the socioeconomic status of a geographical area, the more Medicaid estate planning was reported. Additionally, it was apparent that Medicaid estate planning attorneys concentrated their practices in upper middle class areas. Thus, the following three factors generally went together: (1) an area with a large population of upper middle class elderly; (2) the presence of a number of attorneys who practiced elder law and Medicaid planning as a specialty; and (3) a high level of Medicaid estate planning activity.

There was one notable exception to this generalization. In our site visit to Santa Barbara county in California, eligibility workers reported observing almost no Medicaid estate planning activity whatsoever. Santa Barbara county is one of the wealthiest counties in the country, and many of the nursing facilities in the county are exclusively for private pay patients. Many facilities are not even Medicaid-certified, meaning that they do not accept Medicaid as a form of payment. Apparently, the wealth of many elderly persons in Santa Barbara county is so high that the cost of paying privately for nursing home care is not a financial concern. In addition, if an individual wants to be in one of the better facilities in the county, then Medicaid eligibility is not an option, since the more exclusive facilities are not even certified to accept Medicaid patients.

In every interview we conducted with eligibility workers and their supervisors, we always asked the following question:

> "What percentage of applicants do you think have done something purposively to divest or shelter their assets prior to coming in and applying for Medicaid?"

In cases involving single applicants without spouses, responses to this question generally ranged from 5% to 25%, with most workers estimating that between 5 and 10% of single applicants do some kind of Medicaid estate planning in the pre-application period. For cases involving married applicants, workers consistently estimated a much higher rate of Medicaid planning activity, ranging from 20% to "almost every" application in some counties. Most estimates, however, fell into the 20 to 25% range. As discussed earlier, however, these responses must be evaluated in the context that we selected states and counties where it was generally perceived that a high level of Medicaid estate planning activity was going on. If we had randomly selected states, and counties within states, it is reasonable to assume that workers would have reported lower levels of Medicaid estate planning activity.

2.2 Variations Across States

The magnitude of Medicaid estate planning was not uniform across the four case study states. There was more Medicaid planning activity in New York than the other three states. There was considerable activity in Massachusetts, and there was certainly a very active elder law "industry" in Massachusetts, but it was also clear that recent policy initiatives taken by the Massachusetts Medicaid program had made an impact on reducing the magnitude of Medicaid planning there.

In California, the level of Medicaid planning activity was more sporadic. While most of the counties we visited reported some amount of Medicaid planning by long-term care applicants, it was considerably less than the levels of activity reported in New York and Massachusetts. In San Luis Obispo and Los Angeles counties, eligibility workers reported a fairly high level of Medicaid planning among long-term care applicants.

Similarly, in Florida, the level of Medicaid planning reported by local offices was less than reported in New York and Massachusetts. Since Florida is an "income cap" state, the Medicaid estate planning industry had been hindered by the fact that even if individuals depleted their countable assets through Medicaid estate planning strategies, many were still left with incomes that exceeded Florida's income cap. However, with the enactment of the "income trust" provision in OBRA 1993, the level of planning activity in Florida has recently increased.

Case studies of each of the four states visited during the course of the study are included as Appendices to this report. The case studies provide more detailed information about the magnitude of Medicaid estate planning activity in each state, specific Medicaid planning practices used in each state, and each state's response to Medicaid estate planning as a policy issue.

2.3 Common Medicaid Planning Techniques

This section discusses some of the more common Medicaid planning techniques reported by the Medicaid eligibility workers we interviewed. Since these techniques generally differ for married couples and for single persons, we divide the presentation of techniques by this applicant characteristic.

2.3.1 Medicaid Planning Techniques for Married Couples

Several Medicaid estate planning techniques used in cases involving married applicants stem from the spousal impoverishment provisions of the Medicare Catastrophic Care Act (MCCA) of 1988. Under the provisions of the MCCA, jointly held financial assets are totalled, then divided equally between the institutionalized spouse and the community spouse.[18] One half of the assets are considered to belong to each spouse, and the community spouse is allowed to retain his or her half, subject to both a minimum and maximum amount.[19] At their option, states can also set the *minimum* amount (called the Community Spouse Resource Allowance, or CSRA) anywhere between the established Federal minimum and maximum. Both the minimum and maximum CSRA levels are increased each year in accordance with inflation.[20]

The Medicare Catastrophic Coverage Act of 1988 also provided certain *income* protections for community spouses of institutionalized Medicaid recipients. It is important to note that unlike the treatment of assets, the *incomes* of married applicants are not pooled in determining eligibility for

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[18]Prior to the enactment of the Medicaid spousal impoverishment provisions in MCCA, a community spouse could be left as destitute as the institutionalized spouse. That is because beyond the first full month of institutionalization, income *and* assets of married couples were considered separately. If all of the assets were held in the name of the institutionalized spouse, or were jointly held by both spouses, all of those assets had to be "spent down" prior to Medicaid eligibility. Also, the institutionalized spouse was not allowed to transfer assets to the community spouse. Thus, if the community spouse had no assets in his or her name only, the community spouse could be left totally destitute. Also, policies for diverting income from the institutionalized spouse to the community spouse for the support needs of the community spouse varied from state to state, and were not subject to Federal guaranteed minimums.

[19]In 1995, the minimum amount of assets which the community spouse is allowed to retain (even if it equals more than half of the couple's total assets) is $14,964. The maximum amount (even if it is less than half) is $74,820.

[20]For a summary of Medicaid eligibility for nursing home coverage see Crown, W., Burwell, B., and Alecxih, L. 1994. *An Analysis of Asset Testing for Nursing Home Benefits*. Washington, D.C.: American Association of Retired Persons, Public Policy Institute.

Medicaid. Assets are considered jointly, but income is treated separately. However, MCCA contained additional provisions to ensure that a community spouse has adequate income on which to live by diverting income from the institutionalized spouse. The amount of income to which the community spouse is entitled is called the Minimum Monthly Maintenance Needs Allowance (MMMNA). If the community spouse's own income is below the MMMNA, income from the institutionalized spouse can be diverted to the community spouse, in order to bring the community spouse's income up to the MMMNA.[21] Like the CSRA, the MMMNA is subject to both a Federal minimum and a maximum.[22]

Although the spousal impoverishment provisions enable the community spouse to protect a substantial amount of assets and monthly income, these provisions are also the impetus for three Medicaid estate planning techniques:

- The "Just Say No" strategy.
- Raising the CSRA through fair hearings; and
- Raising the CSRA through court orders;

The "Just Say No" Strategy

Of all the Medicaid planning techniques currently utilized, the "just say no" strategy is, by far, the most egregious. Use of the technique virtually eliminates Medicaid means-testing for married couples when one spouse needs nursing home care. With this technique, the community spouse retains all of the couple's assets, regardless of the total amount, while the institutionalized spouse obtains Medicaid coverage for nursing home care.

Under the "just say no" strategy, the institutionalized spouse first transfers all assets (and sometimes income) to the community spouse, as specifically permitted (without penalty) under MCCA. Then the community spouse simply "refuses" to make any resources available to support the institutionalized spouse. In addition, the institutionalized spouse may execute an assignment of his or her support from the community spouse in favor of the state Medicaid program.

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[21]Note that if the income of the community spouse *exceeds* the MMMNA, the community spouse may retain all of his or her income, and is not required to contribute to the cost of care for the institutionalized spouse (in the vast majority of states) beyond the first month of institutionalization.

[22]In January 1995, the minimum MMMNA was $1,230 per month (150 percent of the Federal poverty level for a couple) and the maximum MMMNA was $1,871 per month.

This strategy emanates from a long-standing Medicaid eligibility policy which allows states to provide Medicaid coverage to applicants who have been truly abandoned by a legally responsible relative, usually a spouse. Historically, these cases usually involved instances where a mother and child have been abandoned by a husband. However, the Medicaid estate planning industry has adopted this long-standing Medicaid provision as a Medicaid planning technique for married long-term care applicants.

Eligibility workers in California, Florida, and Massachusetts reported that the "just say no" strategy was occasionally attempted, but in New York, workers reported that this technique was used widely. Indeed, in Monroe, New York, Nassau, and Suffolk counties, workers reported that "virtually every application" for married applicants involved the use of the "just say no" strategy. Operationally, the use of this technique often involved nothing more than the community spouse checking a box on a form provided to him or her by an attorney or adviser indicating that he or she did not wish to make any income or resources available to the institutionalized spouse.

The use of the "just say no" strategy in New York is due in part to State Social Service Law 366(3)(a) which states:

> Medical Assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of the law.

Elder law attorneys in New York claimed that the New York regulations only reflect the intent of MCCA, which they stated includes specific language allowing for the use of the "just say no" strategy. It is true that MCCA includes language which requires states to extend eligibility to an institutionalized spouse who has assigned his or her support rights from the community spouse to the state. In fact, the language of the New York statute was considered when drafting the spousal impoverishment provisions of MCCA. The bill language is as follows:

> The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—
> "(A) the institutionalized spouse has assigned to the state any rights to support from the community spouse; [Sec. 1924(c)(3)]

However, the MCCA language is silent on the circumstances under which an assignment of support rights is to be considered legitimate and says nothing about the right of a community spouse to refuse support to the institutionalized spouse. In states other than New York, a simple verbal refusal by the community spouse to support the institutionalized spouse is not accepted as a case of true "spousal abandonment" and the Medicaid application is simply denied for excess resources. Indeed, one state—Maryland—enacted a law in 1992 that specifically restricted the assignment of support rights provisions to those situations where needed to actually protect the institutionalized spouse (situations in which the community spouse had truly abandoned the institutionalized and refused to provide any financial support for the care of the institutionalized spouse). The Maryland law also provides for penalties against a community spouse who refuses to pay for his or her spouse's care.

Raising the CSRA through Fair Hearings

If the community spouse's income is below the MMMNA, language in MCCA states that the community spouse can receive additional income and/or resources from the institutionalized spouse to bring her income up to the MMMNA.[23] Through a fair hearing process, the community spouse can have the CSRA raised *above* the state's CSRA maximum to a higher asset level that is necessary to produce enough income to bring the community spouse's income up to the MMMNA.

At face value, this seems like a reasonable policy as long as the institutionalized spouse's income is looked to as the first available resource for increasing the community spouse's income up to the MMMNA. However, another section of MCCA dealing with allowable deductions from the institutionalized spouse's income states that the deduction for the support of the community spouse may only be deducted *"...to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse."* Medicaid planning attorneys argue that this section of MCCA implies that it is not *necessary* to first transfer available income from the institutionalized spouse to the community spouse before determining the additional resources that the community spouse would need in order to bring her income up to the MMMNA.

This point is controversial. If the income of the institutionalized spouse is not looked to first in bringing the community spouse's income up to the MMMNA, significant amounts of assets can be preserved by having the institutionalized spouse *not* make his or her income available to the community spouse. For example, assume that *all* of the income of an institutionalized spouse is used to pay for

[23]For a more detailed explanation of this provision see, for example, Burwell, B. 1991. *Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage.* Cambridge, MA: SysteMetrics, pp. 22-23.

the cost of nursing home coverage, and the community spouse has zero income of her own. If the total assets of the both spouses are invested in holdings yielding five percent per year, the community spouse could retain assets of $448,920 and still have an income below the 1995 maximum MMMNA of $1,871 per month.

Elder law attorneys often argue that the policy should be to raise the CSRA of the community spouse *without* looking first to the income from the institutionalized spouse because the institutionalized spouse's income may be transitory. Consequently, they say, it is important to allow the community spouse to retain enough assets to enable her to support herself if the institutionalized spouse should die. This argument has some merit. However, in deciding whether income should be deemed from the institutionalized spouse to the community spouse, it is also important to consider whether, in fact, the income is transitory. It is not necessarily the case that income from the institutionalized spouse will cease upon death. For example, spousal benefits under Social Security will continue to be paid following the death of the institutionalized spouse, as will survivors benefits from private pensions (if they have been elected). In fact, some income sources, such as life insurance benefits, may become available *only* upon the death of the institutionalized spouse.

The strategy of raising the CSRA level through the fair hearing process was most frequently cited by eligibility workers in Massachusetts. This approach was not used as frequently in the other three states, partly because other planning techniques were equally or more successful and did not require applicants to go through a fair hearing process. In 1994, the three long-term care eligibility offices in Massachusetts were reporting five to 15 fair hearing appeals per month to raise the CSRA in this manner. The workers also found the whole process somewhat frustrating in that they were forced to initially deny eligibility to the applicant (for excess resources), and then look like "the bad guy" when the application was approved during the fair hearing process through an increase in the CSRA for the non-institutionalized spouse.

At the time of our site visit to Massachusetts in December 1993, Massachusetts was *not* using the so-called "income first" rule in bringing the community spouse's income up to the MMMNA.[24] Thus, in those cases in which applicants were requesting fair hearings to increase the MMMNA, substantial levels of assets were being protected for community spouses, often in excess of $200,000. However, Massachusetts was considering changing its regulatory policies to apply the "income first" rule in establishing the MMMNA at the time.

[24]This issue is referred to as the "income first" rule because the question is whether a state looks to the income of the institutionalized spouse *first* before increasing the CSRA to bring the community spouse's income up to the MMMNA.

Concurrently, in March of 1994 the Medicaid Bureau in HCFA issued a memorandum that indicated that since the language in MCCA is not specific on the "income first" rule, that states are free to adopt their own reasonable interpretation of MCCA on this issue:

> ...We would now like to clarify that states have the option to use the "income first" rule or to apply some other reasonable interpretation of the law until we have issued final regulations which specifically address this issue[25]...

In June of 1994, Massachusetts issued new regulations implementing the "income first" policy. Although this change in policy was lobbied against fairly aggressively by the elder law industry in Massachusetts, the new policy was successfully implemented. State Medicaid officials reported that the number of fair hearing appeals to increase the CSRA for community spouses markedly diminished after the new policy went into effect.

However, this issue is also being contested in the courts. In a series of court cases in Ohio, the state initially won a case that determined that the state had the right to apply the "income first" rule, but two more recent court of appeals decisions have ruled that MCCA is "unambiguous" on this issue, and that the statute calls for increasing the MMMNA through a raising of the CSRA level first—before looking to the institutionalized spouse's income.[26] There is also a Federal class action suit pending in the state of Pennsylvania contesting that the state was not providing applicants with any information regarding their rights to seek an increase in the MMMNA by raising the CSRA above the Federal maximum.[27]

Raising the CSRA through Court Orders

Another Medicaid planning technique for raising the CSRA for a community spouse above the Federal maximum is to do so through a court order. This technique is also based upon a provision of the Medicare Catastrophic Coverage Act of 1988, which states that the maximum amount protected

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[25]Memorandum from Sally K. Richardson, Director, Medicaid Bureau, HCFA to All Regional Administrators, March 3, 1994.

[26]See *Kimnach v. Ohio Department of Human Services* (Ct. of Common Pleas, Franklin County, No. 93CVF-06-4191, February 14, 1994); *Kimnach v. Ohio Department of Human Services* (Ohio Ct. App., Franklin County, No. 93APE04-520, 1994 WL 484660, September 8, 1994); and *Gruber V. Ohio Dept. of Human Services* (Ohio App. Ct., No. 94CAE06015, 1994, WL 667869, October 28, 1994). These cases are also summarized in **The ElderLaw Report**, Volume VI, Number 1 (July/August 1994) Number 3 (October 1994) and Number 6 (January 1995).

[27]See Coughlin, Kenneth M. "Class Action Suit Challenges Pennsylvania's 'Income First' Rule." **The ElderLaw Report**, Volume VI, Number 1, July/August 1994.

for a community spouse under the CSRA shall equal the amount provided under a court order, if the court ordered protection exceeds the maximum CSRA allowed under Federal law. Although this provision of MCCA was simply meant to clarify protected assets for a community spouse in cases where a spouse had in fact received assets from a Medicaid applicant under a support order, the provision created a new Medicaid estate planning technique, whereby attorneys have sought court orders specifically to raise the CSRA level for married Medicaid applicants.

During our site visits, eligibility workers in Massachusetts, California and New York reported that court orders were being used as mechanisms to increase the CSRA for community spouses. The technique was particularly common in California, and workers in some counties reported that this technique had become a very routine strategy in cases involving married applicants. One worker reported a case of a court order protecting a million dollar business asset for a community spouse. Workers expressed frustration that there seemed to be nothing they could do to counter this planning strategy, since it seemed clearly permissible under Federal Medicaid law.

In August of 1994, the HCFA Medicaid Bureau issued a letter to the State Medicaid Directors which suggested that states did not have to accept all court orders as replacements for the CSRA. The letter stated:

> We do not believe that the statute contemplates allowing a court, prior to the institutionalized individual applying for Medicaid, to separately establish a spousal share or the protected resource amount. We believe these are administrative determinations which are solely the responsibility of the state agency administering the Medicaid program.

Although some state Medicaid programs initially interpreted this transmittal to mean that eligibility workers could refuse to accept court orders that had clearly been issued merely as a Medicaid estate planning strategy, HCFA issued a subsequent letter to the states in December 1994 that clarified that it only wished to make the point that courts do not themselves have the authority to establish the CSRA, only Medicaid programs have such authority. However, if a court order has been issued which protects the assets of a community spouse in an amount in excess of the Federal CSRA maximum, then the amount protected under the court order does indeed take precedence over the Federal maximum.

Thus, at the time of this writing, court orders remain a viable Medicaid estate planning technique for protecting substantial amounts of assets for community spouses. Without further Congressional clarification on this matter, it is likely that court orders will be used increasingly as a

mechanism for protecting assets for community spouses above the current Federal maximum of $74,820.

2.3.2 Medicaid Planning Techniques for Single Persons

Planned Gifting: The "Half a Loaf" Method

Perhaps the largest "loophole" in Medicaid law and regulation that allows significant transfers of assets to occur is, ironically, the policy on *transfer of asset penalties* itself. The Medicare Catastrophic Coverage Act of 1988 made a number of amendments to the Medicaid statute to clarify how states should treat cases in which asset transfers have occurred, including the imposition of transfer of asset penalties. In general, states are required to impose "periods of ineligibility" in cases where an applicant has transferred a substantial amount of assets in the 36 month period before applying for Medicaid coverage. To use a very simple example, if John Smith transfers $100,000 to his daughter on Monday, and then applies for Medicaid on Tuesday, claiming he has no assets of his own, the state is required to impose a "period of ineligibility" on Mr. Smith, which would render him ineligible for Medicaid coverage until the penalty period runs out.

However, the loophole in the transfer of asset penalty is created in how Congress required states to determine the period of ineligibility. First, the length of the period of ineligibility is determined by dividing the amount of the transfer by the average monthly cost of private nursing home care. Thus, if the average private cost of nursing home care is $3,000 per month, and an applicant has transferred $12,000 prior to applying for Medicaid, then a four-month period of ineligibility would be imposed.

More importantly, however, MCCA stipulated that the period of ineligibility for asset transfers must be imposed from the *date of the transfer*. It is this provision of the policy which creates the loophole. In effect, it allows any applicant to *protect at least half of his or her total assets*. Example 1 provides a typical illustration of how this strategy works.

In effect, the transfer of asset penalty policy allows any individual to transfer half of his or her assets at any point in time, to use the remaining half to pay for private nursing home care, and always have the period of ineligibility expire by the time the remaining assets are depleted. This is why the elder law industry commonly refers to this planning technique as the "half a loaf" method, because one can always save at least half of one's assets through this technique, and "half a loaf is always better than none."

In our site visits, the "half a loaf" method was by far the most common Medicaid planning technique being used by non-married applicants. It is simple, foolproof, and entirely in compliance with Medicaid law. Eligibility workers indicated that only *rarely* did they ever identify an asset transfer in a Medicaid application that actually resulted in a real delay in approving Medicaid eligibility, because in almost all cases, the period of ineligibility on an identified transfer had expired by the time the application was made.

Example 1

How the Medicaid Transfer of Asset Penalty Policy Allows Applicants to Always Protect At Least Half of Their Total Assets

In July 1994, Mrs. Gage, an 86-year-old widow, falls in her own apartment and breaks her hip. After a hospitalization, she is admitted to a nursing home. Medicare covers her first 21-days in the nursing home in full, and Mrs. Gage's Medi-gap coverage pays the $87.50 Medicare copayment requirement for the 22nd to 100th day. However, after 100 days in a nursing home, Mrs. Gage still cannot transfer or ambulate without assistance and therefore cannot be discharged home. She must now pay the $120 per day nursing home charge out of her own resources. She has $42,000 in savings in Certificates of Deposit.

At this point, Mrs. Gage's son seeks the counsel of a Medicaid estate planning attorney to inquire what he can do to prevent his mother from depleting all of her assets in paying for her care. The attorney counsels Mrs. Gage's son to have his mother transfer half of her assets to her children. As counseled, Mrs. Gage transfers $21,000 to her son and daughter. Almost six months later, Mrs. Gage has depleted her remaining assets to $2,000, and she applies for Medicaid. For having transferred the $21,000 to her children six months previously, the Medicaid eligibility worker imposes a "period of ineligibility" on Mrs. Gage. The worker computes the period of ineligibility by dividing the amount transferred ($21,000) by the average private cost of nursing home care in the state, which is determined to be $3,600. The penalty period is thus 5.83 months. By statute, the period of ineligibility is also stipulated to begin on the date of the transfer, which was six months prior to the date that Mrs. Gage applied for Medicaid. Thus, *by the time Mrs. Gage applies for Medicaid, the period of ineligibility has already expired and the eligibility worker approves Mrs. Gage's Medicaid coverage effective immediately.*

In interviews with Congressional staff about the transfer of asset penalty provision, staff agreed that computing the period of ineligibility from the date of the transfer creates a loophole for the Medicaid estate planning industry, but claimed that this policy was consistent with Congressional intent. The intent of this provision, they said, was to protect the "little guy" from being unduly penalized for ingenuous transfers. For example, consider the case of a grandmother who makes a $10,000 gift to her grandson, and then six months later needs to be admitted to a nursing home. Congress wanted to protect such individuals from having periods of ineligibility imposed on them, in cases where relatively small amounts of funds have been transferred or given away without any intent

of depleting assets for Medicaid planning purposes, particularly since the application of penalty periods could result in real hardship on some applicants (i.e., if applicants had depleted their assets yet were also denied eligibility for Medicaid).

Trusts

A major thrust of the OBRA '93 provisions was to limit the use of trusts as a Medicaid planning device. In November of 1994, HCFA issued state Medicaid Manual instructions implementing the OBRA '93 trust provisions.[28] These implementing instructions, while not having the force of law, nonetheless reflect HCFA's regulatory intent. These provisions provide important clarifications to states on how assets held in a trust, as well as how income generated by the principal in a trust, are to be counted in the Medicaid eligibility process. While these provisions are quite extensive, important components of the new provisions include:

- Assets held in a revocable trust are always counted as available to the applicant for Medicaid eligibility purposes;
- Payments made from a revocable trust to any individual or third party other than the applicant are to be treated as a transfer of assets;
- Any income or principal that could be paid from an *irrevocable* trust to the applicant is counted as available income or resources respectively;
- If there are no circumstances under which income or principal from an *irrevocable* trust can be paid to the applicant, then that income and/or principal is not considered available to the applicant, but all such income and/or principal is then considered a transfer of assets for 60 months prior to the Medicaid application date;
- Transfers of a home into an irrevocable trust is to be counted as a transfer of assets, since a home is no longer considered an excluded asset when it is transferred; and
- The above provisions do not apply to certain types of trusts that are specifically exempted under OBRA '93, including (1) special needs trusts, (2) pooled trusts, and (3) income-only, or "Miller," trusts.

Our site visits to four states were conducted prior to the issuance of the HCFA state Medicaid Manual instructions, but nonetheless it was apparent that the OBRA '93 provisions had made a definite impact on reducing the number of trusts being written for Medicaid planning purposes. For example, presenters at a continuing legal education seminar in Boston recommended that attorneys not write any Medicaid planning trusts until HCFA implementing instructions were issued. One elder law attorney we

[28]State Medicaid Manual, Part 3--Eligibility, Transmittal Number 64, November 1994.

interviewed indicated to us that he had stopped writing trust instruments altogether, because as an attorney, it was his fiduciary obligation not to bring his client's financial interests into jeopardy.

Our general observation is that while trusts have been used as a Medicaid planning tool in some cases, their use even prior to OBRA '93 was not particularly widespread. Eligibility workers reported seeing trusts relatively infrequently, maybe one or two per month in their normal caseload. Trusts were more often encountered by workers in New York and Massachusetts than in Florida or California.

Prior to the OBRA '93 provisions, trusts were more frequently used as a Medicaid planning device. In the absence of Federal or state guidelines, workers and their supervisors often based their decisions on whether assets held in the trust were to be considered available to the applicant *by the terms of the trust itself*. Thus, if a trust specifically stipulated that the trust principal could not be made available to provide for the beneficiary's medical or nursing home care, then local eligibility offices frequently abided by the terms of the trust and did not consider the resources as available. In many cases, these determinations were not made by local workers but by supervisors with special expertise or legal counsel who were available to the local offices.

In summary, Medicaid trusts, prior to OBRA '93, were often an effective Medicaid planning device simply because local workers had few state or Federal guidelines by which to make determinations about the countability of resources held in trusts. Even so, trusts were encountered relatively infrequently by workers in their processing of Medicaid applications. With the enactment of the OBRA '93 trust provisions and the subsequent HCFA Medicaid Manual instructions, it is likely that the use of trusts as a Medicaid planning tool will decline, particularly since assets placed in a trust are now subject to a 60-month look-back period. In our judgment, OBRA '93 had the intended effect of greatly limiting trusts as a device for sheltering assets from the Medicaid eligibility process, at least for individuals over the age of 65.[29]

The exceptions extended to special needs trusts and pooled disability trusts will continue to make trusts an effective Medicaid planning tool for disabled persons under the age of 65 who require extended nursing home care, particularly persons with mental retardation and other developmental disabilities. These exceptions allow ways for parents and other relatives of disabled persons to create trusts that can be used to purchase services, equipment or amenities which are not covered by the state Medicaid program for their disabled family members in long-term care facilities. For example, trust

[29]Note, however, that trusts can still be used in conjunction with the "half a loaf" method to shelter assets without actually giving them away. For example, an applicant could create an irrevocable trust with $50,000 in assets, apply for Medicaid two years later, and still not be subject to a penalty period, since the penalty period will already have expired.

resources are sometimes used to purchase assistive technologies such as motorized wheelchairs that are too costly to be covered by some state Medicaid programs.

Annuities

An annuity is a financial instrument that pays a fixed income stream over a defined period of time in return for an initial payment of principal. For example, an individual may buy an annuity for $50,000 that pays him a fixed income of $420 per month over his remaining lifetime. Annuities have been used as a Medicaid planning tool because they are an easy and effective way to quickly convert assets to income.

A Medicaid applicant who purchases an irrevocable annuity that pays a fixed income stream over his remaining lifetime has not really "sheltered" any assets, because the income from the annuity must be used to partially offset the cost of his nursing home care. In this manner, purchasing an annuity only allows a prospective Medicaid applicant to "pay later rather than sooner." Rather than depleting one's assets and then applying for Medicaid, an individual who purchases an annuity might immediately become Medicaid eligible, but then pay a higher proportion of his nursing home bill because his monthly income is now augmented by annuity payments.

Annuities are effective Medicaid planning devices, however, when the income received from the annuity is not actuarially equivalent to the principal payment. For example, if an 80-year-old individual purchases a 20-year annuity, with any remaining payments to be made to heirs upon the purchaser's death, then the purchaser has successfully sheltered assets for heirs.

In our study, we found that annuities were most frequently used as a Medicaid planning tool in the state of California. In California, under current state regulations, irrevocable annuities are not considered an available resource as long as the purchaser is receiving "periodic payments of interest and principal" from the annuity. However, California's regulations are silent on whether the periodic payments have to be actuarially equivalent to the purchase price of the annuity. Thus, an obvious and relatively common technique used by Medicaid planners was to use an applicant's excess assets to purchase an annuity, but then have the annuity make periodic payments of interest and principal of minimal amounts, with any remaining principal and interest passing to heirs on the purchaser's death. For example, one eligibility office in California encountered an annuity worth over $500,000 which only made payments of principal and interest of $5,000 per year (an annual return of about 1%).

Similar examples of excluded annuities with nominal payments of interest and principal were cited by workers in other counties in California. Although the use of these types of annuities as a Medicaid planning device was not widespread, their use was growing, since they were a relatively easy and effective way to quickly shelter assets without incurring a transfer of asset penalty. One eligibility office had also encountered a "private annuity" that involved the purchase of an annuity by the applicant from a relative, rather than from an insurance company or other financial institution, and had been advised by the state to approve it.

In the three other states, annuities were infrequently used as a Medicaid planning device. In these states, eligibility offices generally required annuities to be actuarially equivalent in order to be excluded as countable resources. Eligibility workers in Massachusetts expressed some frustration from not having an official set of actuarial tables approved by the state by which to evaluate the actuarial equivalency of annuities, since elder law attorneys were sometimes presenting their own actuarial tables in the application process. Some workers also expressed a desire to gain access to a set of life expectancy tables that were specifically developed for nursing home patients, since they believed that the life expectancy of nursing home patients was probably less than that of non-institutionalized persons of the same age and sex.

OBRA '93 provisions require that annuities be treated in a manner similar to trusts, and, in the November 1994 state Medicaid Manual transmission, HCFA provided clarification on how annuities are to be treated for Medicaid eligibility purposes. The transmittal adopts the position that in order to be excluded as a countable resource, the expected return on the annuity must be commensurate with a reasonable estimate of the life expectancy of the beneficiary. If not, the beneficiary is presumed not to have received fair market value for the annuity, and a transfer of assets penalty is imposed on the difference between the fair market value and the actual rate of return. For example, if an 80-year-old male purchases a $10,000 annuity with a payout period of ten years, but the life expectancy for an 80-year-old male is only 6.98 years, a transfer of assets penalty is applied to the amount of income that would be paid to the beneficiary between 6.98 years and 10 years. In the state Medicaid Manual transmission, HCFA included life expectancy tables by age and sex that states and local eligibility offices could use to assess the actuarial equivalency of annuities.

"Spending Money"

While not really considered a Medicaid estate planning strategy, it is important to discuss simply "spending money" as a way for Medicaid applicants to reduce their assets to Medicaid eligibility thresholds. Medicaid eligibility workers reported that it is frequently the case that applications will be

denied due to excess resources of relatively small amounts. For example, an applicant may have savings of $9,000, putting her $7,000 over the Medicaid eligibility level of $2,000. In these cases, workers would often advise applicants to spend excess resources on purchases that are excluded in the eligibility determination process. Applicants might be advised to pay off mortgages, credit card debt, or automobile loans; to make home repairs or improvements; or to make some major purchases, such as appliances, furniture, and so forth.

There is nothing illegal about depleting one's assets through simply spending money, and unlike other Medicaid planning techniques, the amount of assets involved are generally minimal. But it is nonetheless important to recognize that it is very easy to reduce assets to Medicaid eligibility levels through these kinds of purchases for applicants who have relatively few assets. Though not required to do so, eligibility workers reported that they often felt an obligation to inform applicants with relatively few assets of the things they could do to deplete their assets by simply spending money, rather than depleting assets on private nursing home care, particularly when workers saw other applicants sheltering significant amounts of wealth with the assistance of elder law attorneys.

Joint Accounts

Prior to OBRA '93, another Medicaid planning technique in some states was to transfer assets through joint bank accounts. For example, in Florida, it was possible to quickly transfer assets by adding a joint signatory to the applicant's bank account, and then have the joint signatory withdraw all of the funds from the account. Until OBRA '93 was enacted, Medicaid policy in Florida ruled that such actions could not be considered as transfers of assets, since the applicant himself had not actively transferred the funds, and the joint owner of the account had every right to withdraw the funds without the applicant's approval.

OBRA '93 clarified that transfers of jointly-held assets that reduce the applicant's ownership or control of the assets are to be considered illegal transfers subject to penalties, regardless of how the transfer was made. Thus, after OBRA '93 was enacted, Florida changed its policy expeditiously, and this Medicaid planning technique is no longer a viable option in Florida.

Burial Trusts

Most states allow funds in an irrevocable burial trust to be excluded in determining eligibility for Medicaid, so that applicants can set aside funds to pre-pay their funeral expenses without having their eligibility for Medicaid affected. These excluded funds are in addition to the $1,500 allowed under

Federal Medicaid law that can be set aside for a burial fund. There have been anecdotal accounts of applicants sheltering significant amounts of assets in irrevocable burial accounts, with the implication that the trustees of such accounts (e.g. a funeral home) may transfer funds not actually used for funeral expenses to the heirs of the Medicaid recipient after his or her death.

Although we asked eligibility workers in all states whether they ever observed funds being sheltered in irrevocable burial accounts, there was very little evidence that this was happening. The most notable exception to this was in Suffolk County in New York where eligibility workers reported that they occasionally saw very large pre-paid burial accounts (e.g. bronze caskets costing twenty to thirty thousand dollars). In general, however, we uncovered little evidence that burial accounts were being used as a Medicaid planning tool in the four states we visited.

2.4 The Variable Effectiveness of Estate Recovery Programs

Another component of Medicaid estate planning involves protecting assets still held by Medicaid recipients while they are alive (primarily the Medicaid recipient's home, but also other assets that are excluded in the Medicaid eligibility determination process) from being recovered by states after the Medicaid recipient dies. The process of recouping costs incurred by Medicaid recipients from their estates after their death is called *estate recovery*. Prior to OBRA '93, Medicaid estate planning to protect assets from state recovery was not even needed in many instances, since half the states did not even operate estate recovery programs. However, an important provision of OBRA '93 was to require *all* states to implement estate recovery programs.

In most states that operate estate recovery programs the process works something like the following:

- Medicaid recovery staff collect information for various sources on *all* recent decedents, all recent decedents who were enrolled in Medicaid prior to their death, or all decedents in nursing homes;
- Names (and other identifying information) of decedents are entered into the Medicaid MMIS system and matched against Medicaid enrollment and claims files to determine the amount of Medicaid payments made for Medicaid-covered services used by decedents prior to their death;
- If a "hit" is found, a notification letter is sent out to the executor of the estate and/or to prospective heirs indicating the amount of the state's claim against the Medicaid recipient's estate;
- The state's claim against the estate is resolved in accordance with state law regarding the relative precedence of alternative creditors against an estate. For example, the claim of

Medicaid estate recovery programs against the estate is usually secondary to the claims of funeral homes and estate administrators;

- In addition, if the state has imposed a lien on the home of the Medicaid recipient, the lien is not released (and, therefore, the home cannot be sold or the deed transferred) until the state's claim is settled.

All of the four case study states operated estate recovery programs prior to OBRA '93, but each state's program differed substantially in their effectiveness and structure. Massachusetts and California operated centralized estate recovery programs within the Third Party Liability Branches of their state Medicaid program offices. In New York, estate recovery was a county responsibility, so that estate recovery policies and practices differed from county to county. Florida was operating a minimal estate recovery program at the time of our site visit, contracting with one attorney to recover from estates on a contingency basis, but was in the process of planning for a major expansion in its estate recovery efforts.

Of the four states, Massachusetts had the most effective estate recovery program. As a result of state legislation enacted in 1992, the executors of *all* probated estates are now required to notify the Division of Medical Assistance of the petition to probate. This provides the state with an effective system for notification of deaths of Medicaid recipients, which are currently about 2,000 per year. The Division of Medical Assistance then cross references the notifications it receives about all probated estates with its Medicaid eligibility files to identify persons who have received Medicaid payments for services, and if so, the total payments made for the services received. To further protect its claim, Massachusetts also places a notification lien on the property of Medicaid recipients without a community spouse (or other exempt relative) so that the home cannot be sold or transferred without prior settlement of the state's claim on the property.

California, like Massachusetts, operates a centralized estate recovery program that comprehensively identifies all recent Medicaid deaths and pursues recoveries from the probated estates of decedents who have received Medicaid-financed services. However, the effectiveness of California's estate recovery is limited by two major factors: (1) the state does not impose liens on the property of single Medicaid recipients to protect its claim; and (2) the state does not impose transfer of asset penalties in cases where homes have been transferred for less than fair market value either prior to Medicaid application or after Medicaid enrollment. Thus, Medicaid recipients can generally transfer their homes prior to death, and thus avoid having their property become part of their probated estates. California estate recovery program staff admitted that they generally are successful in making recoveries from real property only in cases where Medicaid recipients and their families are uninformed about Medicaid estate planning opportunities for transferring homes prior to death. Thus, recoveries

are generally made from "modest" estates, while recipients who own property of significant value are more informed about Medicaid estate planning practices and are successful in avoiding the estate recovery process. While the California state legislature had enacted a lien program, the program has not been implemented since the state believes it would only accelerate the transfer of homes in order to avoid the placement of liens.

In New York, estate recovery is entirely a county responsibility, so that estate recovery practices vary widely from county to county. Estate recovery in New York is a much more haphazard process, since there are no uniform procedures across counties for placing liens on exempt property (although most counties do place liens) for identifying recent deaths of Medicaid recipients, for obtaining information on incurred Medicaid costs by recent decedents, or for pursuing claims against estates in local surrogate courts.

Local county staff in New York involved in estate recovery efforts expressed considerable frustration regarding the estate recovery process, and felt there were many barriers in the way of enhancing the effectiveness of their efforts. For example, there was considerably more litigation in New York regarding Medicaid estate recovery. Heirs to the estates of recent Medicaid recipients were much more aggressive in protesting the counties claims for recovery. Local county staff often claimed that they did not have the resources to litigate protested claims, and freely admitted that they often do not pursue recoveries in many cases because they believe it is going to be "a waste of time." Further, many respondents claimed that the local surrogate courts tend to rule in favor of heirs in protested cases, thereby reducing the county's incentive to pursue recoveries.

Florida had the weakest estate recovery program of the four states. Florida's estate recovery program consisted of a contract with one attorney who was responsible for seeking Medicaid recoveries across the state. Florida's estate recovery efforts are hindered significantly by the fact that the Florida state constitution contains a specific "homestead exemption" which protects homes in the probate process from the claims of creditors, so that homes are generally allowed to pass to heirs, regardless of the amount of claims against the estate by outside creditors. Thus, Florida's estate recovery program almost never makes recoveries from the real property of deceased Medicaid recipients, and the recoveries it does make are from property other than the home. Since the vast majority of Medicaid estate recoveries in other states are derived from real property, Florida's opportunities for substantially increasing recoveries without modifying the homestead exemption in the state constitution are severely limited. State Medicaid staff believed the likelihood of the state legislature making such a change was slim.

Seeking Recoveries from the Surviving Spouse's Estate

Given that the Medicaid spousal impoverishment provisions allow community spouses to retain much higher levels of assets (as well as the home) than prior to the enactment of MCCA in 1988, there is considerable opportunity for increasing the effectiveness of estate recovery efforts if states continue to pursue claims against the estates of surviving spouses. Federal Medicaid statutes have not specifically addressed whether states have the right to pursue claims against surviving spouses, although various court decisions have generally ruled that states *do* have the right to pursue such recoveries.[30]

At the time of our site visits, Massachusetts and California were just beginning to pursue recoveries from the estates of surviving spouses. California had enacted legislation to impose liens on the property of surviving spouses in order to protect its claims over the remaining lifetime of a surviving spouse, but had not implemented the lien program. Massachusetts pursued claims on the property of surviving spouses, although it did not have a formal lien program. Although counties in New York had the right to pursue recoveries from the estates of surviving spouses, few counties pursued such claims due to recent judicial decisions that severely restricted the authority of counties to recover their claims. Florida was not pursuing recoveries from the estates of surviving spouses at all. Thus, while states recognized the potential benefit of pursuing recoveries from the estates of surviving spouses, none of the four states in our study were actually making significant recoveries from spousal estates.

A major barrier to the pursuit of claims against the property of surviving spouses is that *without a lien* on the property of the surviving spouse to protect its claim, there is nothing to prevent the surviving spouse from transferring assets out of his or her estate in order to avoid recovery. The only situation where transferring assets could have negative consequences is if the *surviving spouse* later applies for Medicaid and incurs a penalty period. On the other hand, the placement of liens on the property of surviving spouses can have negative consequences if, for example, the surviving spouse needs to sell the property at some point in order to meet basic living expenses. Thus, an equitable policy approach for protecting the state's claim to eventually recover from the estate of the surviving spouse while at the same time not imposing undue hardship on the surviving spouse during his or her remaining lifetime is not a simple matter.

[30]For example, a recent decision in Federal district court in California ruled that the restriction on the placement of liens on the property of community spouses is only applicable during the lifetime of the institutionalized spouse, and that the imposition of liens against property that has passed to a surviving spouses upon the death of a Medicaid recipient does not conflict with federal Medicaid statute. See *Lynn Roy Demille et al. v. Kimberly Belshe et al.*, No. C-94-0726-VRW.

Of course, if states are going to pursue recoveries from the estates of surviving spouses, they must develop systems that can track surviving spouses and notify the state at the time of their deaths. This is not a straightforward matter since, for example, surviving spouses could move out of the state that is pursuing a claim.

State Plans for Implementing the Estate Recovery Provisions of OBRA '93

In May of 1994, HCFA conducted a survey of the states to gauge the impacts of OBRA '93 on their estate recovery programs. Twenty-seven states were found to have been operating estate recovery programs prior to OBRA '93. Thirty states indicated that they required legislation to establish estate recovery programs or to change their existing ones in response to OBRA '93. Thirty-one states indicated that they planned to use liens, 10 had decided that they would not, and the remainder were either undecided or did not answer the question.

These results should be interpreted cautiously, however. Many states may have changed their plans for how to implement the estate recovery provisions of OBRA '93 since the survey was taken.

2.5 Medicaid Estate Planning and State Administrative Practices

Federal and state initiatives to enact and implement eligibility policies and estate recovery programs that address new Medicaid estate planning strategies are important to ensuring that Medicaid remains targeted to the truly poor. However, there is another equally important component—the *administration* of Medicaid eligibility procedures. State administrative practices to *verify* income and assets reported by applicants during the eligibility process can be equally, if not more, important as the specific eligibility policies adopted by a state. In their efforts to contain Medicaid long-term care costs by limiting nursing home coverage to those persons who meet Medicaid's financial criteria, states can realize additional savings by not only tightening up their eligibility policies, but by implementing administrative practices that improve the verification of income and assets reported on Medicaid applications.

When an individual or married couple apply for Medicaid coverage, they first complete a Medicaid application that asks a series of questions about their financial circumstances. These applications are not uniform across states; each state Medicaid program develops its own administrative procedures for processing applications. Some states use generic applications for all Medicaid applicants, while other states have separate applications depending upon the type of applicant and coverage requested. In response to the growth in Medicaid estate planning, some states have revised

their applications for nursing home coverage. They now ask much more detailed questions about assets held by the applicant, including specific questions about assets held in trusts, annuities, jointly held assets, business property, vacation property, and so on.

Along with the application, applicants must provide documentation of reported financial information. This documentation may include the following:

- Proof of reported income
- Copies of property tax receipts
- Bank statements for saving accounts, checking accounts, and other financial accounts[31]
- Insurance policies
- Car registration
- Property deed(s)
- Copies of any pre-paid burial arrangements
- Annuities
- Trust documents
- Documents verifying ownership of stocks, bonds, etc.

During processing of the Medicaid application, the eligibility worker is responsible for ensuring the application is complete and accurate, and the applicant has provided the requisite supporting documentation. The eligibility worker must then review all of the material provided by the applicant and either approve or deny Medicaid coverage, depending upon whether the applicant has met the program's financial criteria. In reviewing the application, the eligibility worker may also conduct further investigations on his or her own to assess whether the applicant has reported his or her financial status accurately.

By and large, the eligibility workers we interviewed did not do any "investigative" work of their own to ensure that the information provided on applications is complete and accurate. Most workers stated that they did not have the time or the resources to do so. For example, applicants are required to report all assets held in bank accounts. While workers might verify with the bank that the account balances reported on the application are accurate, and that the applicant has no other active accounts with the bank, workers generally do not do additional "bank checks" to determine whether the applicant may have additional accounts at other local banks that are not reported on the application. Workers often stated that it is difficult enough to get cooperation from banks that *are* reported on applications, since banks consider inquiries from local eligibility offices as an administrative burden for which they receive no compensation.

[31]The number of months of bank statements that applicants must submit with their application varies from state to state.

Additionally, eligibility workers do not generally conduct property checks to assess whether applicants may have additional real property not reported on the application. Some workers contended that this would be a difficult task in any case, since property owned by the applicant, or jointly owned, might be listed under someone else's name in local property records. Most towns and municipalities do not have automated listings of property records, so that property checks of this kind can be time consuming. Workers also reported that there is generally no way to determine whether applicants may own property outside the county (or state) in which the applicant resides.

Eligibility workers reported that they did not have the time to conduct additional investigative work of their own, that it was difficult enough just meeting their processing quotas and obtaining the required documentation from applicants. Most of the workers we interviewed stated that they thought applicants were "generally honest" and did not consciously withhold information about their financial situation. However, a number of workers indicated that while applicants were usually honest when asked direct questions about their financial circumstances, that most applicants did not volunteer information unless directly asked.

IRS Matches

All Medicaid programs are required to participate in the Income Verification Eligibility System (IVES). Under IVES, computer matches are conducted with the Social Security numbers of new Medicaid applicants and Form 1099 returns submitted by banks and other financial institutions. Thus, if a Medicaid applicant has any financial asset which generates interest or dividend income that is reported to the IRS on a Form 1099, this income should be identified through the IVES program.

The primary problem with the IVES program is the time lag of the computer matches. When local eligibility offices submit the Social Security numbers of new Medicaid applicants to the IRS for matching, the interest and dividend information that is returned to the local offices is usually 18-24 months out of date. For example, if a local office receives a new Medicaid application in June of 1994, the IRS match will provide the office with information about the applicant's interest and dividend income for 1992. Thus, if the IVES match uncovers a financial account not reported by the applicant on his or her application, it may be simply be due to the fact that the applicant closed out the account during the intervening period. Thus, every time the IVES match produces a "hit" (a discrepancy) the worker must ascertain the reason for the discrepancy.

A second problem is that the computer matches with IRS data are done through "batch" processing rather than through an on-line system. Often the Medicaid application has already been

processed and approved before the information from the IVES match is provided back to the local office. Thus, once the computer matches come through, workers must evaluate the information and determine whether it is worth "opening the case" again to investigate the "hit." As previously discussed, workers often do not have the time to thoroughly investigate all cases.

Despite these problems, workers were generally supportive of the IVES program, primarily for its deterrent effects. Just informing applicants of the fact that the information provided on their applications would be checked with IRS computer files, they said, increased the veracity and completeness of the applications.

The Importance of the Long-Term Care Eligibility Worker

During the course of our site visits to eligibility offices in four different states, it became apparent that the training, experience, and diligence of the local eligibility worker was an important factor in addressing Medicaid estate planning issues. While most workers felt that applicants were generally honest in providing financial information (and it should be recognized that the individual completing the application for a nursing home recipient is generally not the applicant him or herself but rather another family member) experienced workers also stated that they could generally tell when applicants were not being completely forthright about reporting their finances. This was often taken as a sign that the application should be reviewed with greater scrutiny.

Relatedly, it clearly made a difference as to whether a worker specialized in processing long-term care applications, or whether a worker was a "generic" worker who processed all types of Medicaid applications. Although all of the front-line eligibility workers we interviewed were paid low salaries (salaries generally ranged between $17,000 and $25,000 annually), the processing of long-term care applications requires a high skill level. Workers must be able to evaluate a much wide range of financial instruments, including retirement plans, pension funds, stocks, bonds, IRAs, trusts, annuities, business investments, real estate holdings, life estates, and so on. Workers with many years of experience stated that the complexity of Medicaid applications for long term coverage has increased dramatically in the last ten years, since elderly applicants are now much more likely to have a broad range of financial assets. The enactment of the Medicaid spousal impoverishment provisions under MCCA has also brought a lot more middle-class elderly couples into the Medicaid program.

Workers who specialized in long-term care applications were clearly more knowledgeable about Medicaid planning issues than the "generic" workers we interviewed. In most of the largest counties we visited, such as in Los Angeles and Miami, eligibility offices were able to support long-term care

specialists. However, in many of the smaller counties, workers tended to be generic. The largest degree of specialization occurred in Massachusetts, which has only three long-term care eligibility offices serving the entire state. The workers in these offices, some of whom had many years of experience, were impressively knowledgeable about asset divestiture and sheltering strategies.

Florida had recently implemented an automated welfare eligibility system called FLORIDA. While most of the workers we interviewed said that the automated system represented a significant overall improvement in processing welfare applications, it was clear that in regard to the processing of Medicaid long-term care applications, that the new system had lessened the investigative role of the eligibility worker in the eligibility determination process. Rather than relying on the worker's individual judgment in evaluating an applicant's financial circumstances, the automated system leads all workers through the same series of modules in making inquiries about the applicant's income, liquid assets, exempt assets, property, and so on. If a question is not asked as part of the automated system, then the question is not asked by the worker. Thus, the "investigative" nature of the eligibility worker's job had clearly been mitigated by Florida's automated eligibility system.

3.0 DISCUSSION

3.1 Impact of OBRA 1993 on Medicaid Estate Planning

The OBRA 1993 provisions on transfers of assets, trusts, and estate recovery programs have made a definite impact on Medicaid estate planning, although many opportunities for Medicaid estate planning remain unaffected. First, the provisions closed a number of loopholes that were being increasingly used by the Medicaid estate planning industry to transfer countable assets without penalty. These loopholes included making multiple transfers to incur concurrent penalty periods, transferring assets through joint bank accounts, and purchasing annuities that are not actuarially equivalent.

Second, the OBRA '93 provisions greatly clarified Medicaid eligibility policy in regard to assets transferred into trusts. The provisions largely preclude the use of trusts as a Medicaid planning device, unless someone is foresighted enough to place their assets into a trust five years prior to making an application for Medicaid coverage. All assets held in a trust will be considered countable assets if the applicant has any means of accessing the corpus of the trust, or if the trustee has any discretion over the distribution of the trust principal, at present or at any time in the future. If trusts assets are not available to either the applicant or the trustee, and are not countable, then, the transfer of assets into an irrevocable trust will be treated as a transfer subject to penalty with a 60-month look-back period.

Further, the OBRA '93 provisions and subsequent administrative guidelines have served to make the treatment of assets held in trusts much more consistent across all states. Prior to OBRA '93, state and local eligibility offices were clearly not evaluating trust assets with any degree of uniformity.

In regard to their impact on Medicaid expenditures for nursing home care, it is likely that the estate recovery provisions of OBRA '93 will have a larger impact than the transfer of asset and trust provisions. All states are now required to implement an estate recovery program, whereas prior to OBRA '93, only half the states had operational programs. The option to states to expand their scope of estate recovery beyond probated estates will also limit the ability of Medicaid estate planners to avoid estate recovery by avoiding probate through life estates, rights of survivorship, trusts, and other sophisticated estate planning instruments, if states choose to adopt the expanded definition of "estate." However, at the time of this writing, none of the four case study states had adopted the broader definition of "estate" for estate recovery purposes.

OBRA '93 also made an important impact in the message it implicitly sent, i.e., that Congress intends to maintain Medicaid as a means-tested program targeted to those people who truly cannot

afford to pay for nursing home care from their own private resources, and that preserving inheritances for heirs is *not* one of Medicaid's policy objectives. This message will have an effect on the elder law industry as it seeks to devise new Medicaid estate planning techniques. Since elder law attorneys must act in their client's financial self-interest, they are likely be more risk adverse in placing their clients' finances into devices that may be subject to further Congressional scrutiny in the future.

OBRA '93 was not a one-sided piece of legislation, however. It also expanded Medicaid coverage to certain individuals who had previously been unable to obtain Medicaid eligibility, namely individuals with incomes over 300% of the Federal SSI benefit level who happen to live in "income cap" states. As the "income trust" provision of OBRA '93 becomes more fully implemented, it may put increasing pressure on income cap states to terminate the "income cap" option altogether and to extend nursing home coverage to the medically needy. While many would consider this change a positive step, and a more equitable long-term care policy, it will definitely have the effect of *increasing* Medicaid expenditures in income cap states.

3.2 State Opportunities for Further Tightening the System

Beyond implementing all of the OBRA '93 provisions (and at the time of this writing, many states still have not) what can states do on their own to further tighten their Medicaid eligibility systems for nursing home coverage? We believe there are two major areas. First, there are many options available to states to increase the effectiveness of their estate recovery programs. Second, there are a number of administrative practices which states could implement to ensure that income and assets are accurately reported on Medicaid applications.

Although OBRA '93 requires all states to implement estate recovery programs, it leaves considerable discretion to the states in regard to the aggressiveness of such programs. For example, Congress allows but does not require states to place liens on the real property of Medicaid recipients in nursing homes. The placement of a lien on the homes of single Medicaid recipients without spouses (or other exemptions) is the most effective mechanism for ensuring that the equity in a private residence is used to offset Medicaid payments for nursing home care upon the recipient's eventual death or sale of the home. Without a lien, the likelihood of the home remaining in the recipient's estate upon his or her death, and available for recovery, diminishes greatly.

The pursuit of a claim on a surviving spouse's estate, in order to eventually recover Medicaid costs incurred by the deceased spouse, is another mechanism that is potentially available to states to increase estate recoveries. At this point in time, very few states pursue estate recovery this

extensively. Most states allow estates to pass to surviving spouses without any subsequent recovery after the death of the surviving spouse. However, this option may become increasingly attractive to states as they implement and expand their estate recovery programs.

We feel there are also substantial opportunities for states to tighten their Medicaid eligibility systems through improved administrative practices. While workers reported that most applicants are generally honest in reporting their financial status on Medicaid applications, there are always some who are not. As previously discussed, it is usually not the applicant herself who completes the application, but a child or other relative who may have a direct financial interest in not revealing all of the parent's financial holdings.

The main barrier to improved administrative practices in the states we visited was staffing resources. Eligibility workers do not have the luxury of spending a lot of time investigating their cases. With few exceptions, workers are forced to rely almost exclusively on the information provided directly by the applicant.

Computer matches are undoubtedly a cost-effective mechanism for verifying financial data on Medicaid applicants. To be effective, however, such matches must be productive (they must actually identify resources that would otherwise remain unidentified), timely (they must produce information that accurately represents applicants' *current* financial situation), and efficient (they must not require more resources to conduct than are returned to the system through improved resource identification). Thus, computer matches should not be conducted just for the sake of providing more information. Workers can be overburdened with too much information. But increased computer matching in some cases may be warranted. Pilot programs, such as those being tried to increase property checks in Massachusetts, are a good way of testing new administrative techniques before implementing them statewide.

It is difficult to recommend specific types of computer matching initiatives, since the logic of such initiatives depends upon the availability of potential databases in each state. However, since home equity represents such a large percentage of the total wealth of elderly persons, it is logical to consider improved practices to identify real property holdings of Medicaid applicants (or property that the applicant may have transferred in the 36-month look-back period) as a priority.

It is important also not to underestimate the potential benefits of additional investments in *personnel*. Since Medicaid long-term care applications are becoming increasingly complex, states might consider increasing investments in long-term care eligibility specialists. This investment could be in

the form of specialized training and/or improved salary compensation. The return on such investments could be significant.

3.3 The Inequities of Medicaid Estate Planning

Medicaid eligibility staff in all of the states mentioned the inequities that arise as a result of Medicaid estate planning due to unequal access to legal advice. As a result of differential access to legal advice, applicants for Medicaid nursing home coverage in equal financial circumstances can retain very different amounts of assets and still be eligible for Medicaid. A common example of such an inequity occurs in determining the CSRA level in cases involving a community spouse. Applicants with access to legal advice are often able to raise the CSRA above the limit determined during the eligibility process (and even above the Federal CSRA maximum) through fair hearings or court orders. This, of course, enables the community spouse to preserve substantially more assets than would otherwise be the case. However, other couples of essentially the same economic status but who do not happen to seek legal advice can end up spending down far more of their assets. In essence, eligibility rules are more liberal for those with access to legal advice. Similar inequities arise, of course, with regard to legal advice concerning other types of Medicaid estate planning techniques (e.g., nondiscretionary trusts, life estates, annuities, and asset dispersement strategies).

Medicaid estate planning also creates equity issues across income classes because those with more wealth are more likely to have access to legal advice. This not only influences eligibility for Medicaid nursing home coverage, as discussed above, but protection from estate recovery programs as well. Because of this, Medicaid estate recovery programs have been referred to as "Picking the Bones of the Poor."[32] This equity issue might be dealt with by establishing a threshold value that would be exempt from estate recovery, so that estates of low value would be protected.

3.4 The Politics of Medicaid Estate Planning

Federal and state initiatives to address Medicaid estate planning as a policy issue involve political, as well as technical, considerations. In our study, it was clear that political forces played an important factor in states' responses to OBRA '93, in their implementation of the OBRA '93 provisions, and in states' administrative practices in the eligibility process.

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[32]Commission on Legal Problems of the Elderly. 1994. **Medicaid Estate Recovery Under OBRA '93: Picking the Bones of the Poor?** Washington, DC (November).

We observed diametrically opposed political climates in Massachusetts and New York. Massachusetts was moving in a more conservative direction, making a concerted effort to tighten up its eligibility system for long-term care, despite political opposition from advocacy organizations and the elder law industry. The administration in Massachusetts had made a clear policy decision to reduce opportunities for Medicaid planning as part of its overall effort to contain the growth in Medicaid program expenditures. Massachusetts had recently implemented a TEFRA lien provision, enhanced its estate recovery program, tightened its treatment of Medicaid planning trusts, applied the "income first" rule in determining the community spouse's CSRA level, and initiated a pilot program in one of its offices to improve the verification of real property holdings.

In New York, on the other hand, there seemed to be little political motivation to tighten the system.[33] Although Medicaid program administrators we interviewed at the state and local level for the most part supported efforts to attack Medicaid estate planning, they reported that there was virtually no support in the state legislature for doing so. The general observation was that Medicaid coverage for long-term care had grown into such a middle class benefit, that the prospects of reverting it back to a truly means-tested benefit were gloomy. For example, although one of the OBRA '93 provisions—the option to impose transfer of asset rules on applicants for noninstitutional long-term care services—was specifically included as a result of lobbying by New York state officials, the state legislature has so far failed to adopt this provision into state law.

In California, Medicaid estate planning did not appear to be a visible political issue. California has traditionally contained Medicaid nursing home costs by restricting the growth in nursing home reimbursement rates. Some respondents believed that low nursing home payment rates had created a discernible difference between the quality of care for private patients and for Medicaid patients in California, which acted as a deterrent to Medicaid estate planning, at least in some areas.

A political force that played a critical role in California more than in the other three states were elder advocacy organizations. These organizations took a very aggressive position with the state in regard to the interpretation of Federal Medicaid statutes, and frequently threatened to sue (and did sue) if they felt the state was implementing Federal law in a more restrictive manner than Congress intended. This constant threat of litigation appeared to have a definite impact on how California has chosen to implement Medicaid eligibility policy for long-term care coverage.

[33]Since we conducted our site visit in New York, of course, there has been a shift in administration as a result of the gubernatorial election in November of 1994.

The main political issue in Florida clearly centered on the "homestead exemption." Although the state administration was supportive of efforts to enhance estate recovery efforts, the issue of whether estate recovery could include placing a lien on the private residences of Medicaid nursing home residents was a "hot" political topic. On this issue, the Medicaid program office needed support from the state Attorney General's office to pursue the legalities of adopting a TEFRA lien program, given the construct of the homestead exemption in the state constitution. After reviewing the issue, the Attorney General's office concluded that the state's homestead exemption prohibited the state Medicaid program from filing liens (voluntary or involuntary) against homestead property.

3.5 Options for Further Federal Reform

Should the Congress decide to enact further reforms to tighten the Medicaid eligibility system for long-term care coverage, and to pursue estate recovery efforts more aggressively, there are additional options available that were not addressed in OBRA '93. These options include:

- *Amend Federal law to limit transfers from the community spouse to a third party "for the sole benefit of the community spouse."* OBRA '93 precludes states from imposing transfer of asset penalties on transfers "from the individual's spouse to another for the sole benefit of the spouse." This provision creates a loophole that allows married couples the option of transferring all of their jointly held assets to the community spouse prior to Medicaid application, and then transferring all of the community spouse's assets to a third party for the sole benefit of the community spouse. For example, the community spouse could use all of the couple's assets to purchase an actuarially equivalent annuity that converts all of his or her assets to an income stream paid solely to the community spouse. Since income of married couples is treated separately in the Medicaid eligibility process, there is no limit to the amount of assets that can be protected through this planning technique. A community spouse can potentially convert $1,000,000 to an actuarially equivalent annuity, and thus shelter all of the assets in this manner. Further, since the community spouse is not required to contribute to the cost of care for the *institutionalized* spouse, none of the income received by the community spouse from such an annuity would be required to help pay for the institutionalized spouse's care.[34] One option is to limit transfers of this type to those that would increase the community spouse's income to the maximum MMMNA allowed. Transfers which would

[34] Although we did not observe this technique being used by married applicants during our site visits, it is clear that this technique will be increasingly used as a result of HCFA's recent clarification of this provision of OBRA 93. See, for example, "A Gift from the Feds to Cheer Everyone Involved in Elder Law." Alexander Bove, *The Boston Globe*, January 1995, and "HCFA Explains OBRA-93...More or Less," The ElderLaw Report, Volume VI, Number 6, January 1995.

increase the community spouse's income above the MMMNA could be treated as transfers subject to penalty. *An additional option would be to pool the income as well as the resources of both spouses in the initial determination of eligibility for the institutionalized spouse, and only allow the community spouse to retain income up to the MMMNA level.*

- *Address the "half a loaf" strategy by changing the date on which the transfer of asset penalty period begins*. The success of the "half a loaf" strategy relates to the fact that the penalty period for transfers begins on *the date of the transfer*. An alternative option that would preclude applicants from using this strategy is to begin the penalty period on the date the applicant *would otherwise have been eligible for Medicaid*. Thus, if an applicant transferred $20,000 in July of 1994 and applied for Medicaid in January 1995 (and was otherwise determined eligible) the penalty period might begin in January 1995, not July 1994. Should the asset transfer provision be so revised, it might be appropriate to retain some flexibility in the new provision so that applicants who have unwittingly transferred relatively small amounts of assets prior to application are not unduly penalized.

- *Amend Federal law to clarify that transfer of asset penalties will be applied to transfers that are done for the purpose of establishing eligibility for Medicaid or to avoid estate recovery*. California does not presently apply transfer of asset penalties to transfers of exempt property, including the home, due to a court case ruling that interpreted Federal Medicaid law to mean that transfer of asset penalties can only be applied to cases in which transfers are made for the purpose of establishing eligibility for Medicaid. Since a home is exempt property in determining Medicaid eligibility, the court ruled, then transfer of asset penalties *cannot* be applied to transfer of the home, since such transfers are not done to establish Medicaid eligibility. Rather, transfers of the home are usually done to avoid state claims against the home in estate recovery programs. Thus, Congress may wish to clarify that transfers made for the purpose of establishing eligibility for Medicaid *or* to avoid estate recovery are both subject to penalties.

- *Amend Federal Medicaid law to clarify the circumstances under which an institutionalized spouse in long-term care should be deemed eligible for Medicaid when the community spouse "refuses to support" the institutionalized spouse*. This amendment would preclude applicants from utilizing the "just say no" strategy as is presently being used in New York state to preserve all of a married couple's assets for the community spouse. The amendment could clarify that evidence of true abandonment by the community spouse is necessary before an institutionalized spouse can be deemed eligible for Medicaid without counting the resources of the community spouse as available to the institutionalized spouse.

- *Clarify the rights of Medicaid estate recovery programs to recover from the estates of surviving spouses of deceased Medicaid recipients*. Medicaid law presently prohibits states from placing liens on the homes of the community spouse during the life of the institutionalized spouse receiving Medicaid. At the same time, the Medicaid spousal impoverishment provisions, and various Medicaid estate planning strategies, have increased opportunities for community spouses to retain much higher levels of assets while the institutionalized spouse is on Medicaid. Most states do not pursue recovery from the estates of surviving spouses. The legality of placing liens upon the property of surviving spouses *upon the death* of the institutionalized spouse on Medicaid is ambiguous in Federal law. Thus, Congress may want to clarify Federal law in regard to the right of states to protect its claims through the placement of liens on the property of surviving spouses after the death of the institutionalized spouse.

- *Clarify Federal law in regard to the "income first" rule for raising the CSRA.* Without Congressional clarification on the "income first" rule, it appears that the ambiguity in the MCCA language regarding this issue will result in numerous court cases on the matter. A relatively simple clarification that stipulates that the income of the institutionalized spouse will be used first to bring the community spouse's income up to the MMMNA, before increasing the CSRA, would appear to resolve this matter.

- *Clarify Federal law in regard to the use of court orders to increase the CSRA for the community spouse*. Without clarification of the circumstances under which court ordered levels of protected assets for community spouses are to be applied in place of the Federal CSRA maximum, it is likely that applicants and elder law attorneys will increasingly seek court orders as a mechanism for increasing the CSRA for couples with substantial levels of assets.

- *Allow/require Medicaid applicants to provide copies of Federal tax returns as documentation of their financial situation in the Medicaid eligibility process*. Federal income tax returns provide a lot of useful information that can be used to verify the income and assets reported on Medicaid applications. For instance, unearned income from savings accounts, stocks, bonds, trusts, etc. are reported on Schedule B. Property taxes on real property (regardless of the location of the property) are reported as deductions on Schedule A. Gifts in excess of $10,000 are also reported. The confidentiality of Federal tax return data are a barrier to requiring applicants to submit these data as part of the Medicaid application process.

The above recommendations focus on relatively minor changes in Federal law to close Medicaid eligibility loopholes. They do *not* include recommendations that would reflect substantial shifts in

Federal policy. Examples of options that would reflect a more aggressive shift in Federal policy might include: (1) *requiring* states to impose liens on real property as part of their estate recovery programs; (2) pooling the *income* as well as the assets of married couples in determining Medicaid eligibility for the institutionalized spouse; and/or (3) modifying the "intent to return" rule such that homes would only remain an exempt resource as long as there is a medically-certified likelihood that a Medicaid recipient will be discharged from nursing home care.

3.6 Treatment of the Home: What's the Fair Policy?

Real property of deceased Medicaid recipients (usually the home) is the primary source of collections in terms of both frequency and dollar amounts recovered in estate recovery programs. Even so, only 14 of the 27 states that currently have estate recovery programs place liens on the property of Medicaid long-term care recipients.[35] One reason for this, mentioned earlier, is that some states have homestead laws that limit the ability of states to place liens. Given the emotional attachments that people have to their homes, and their desire to pass the family home on to heirs, the placement of Medicaid liens on homes is also a sensitive political issue that many state legislatures prefer to avoid.

Were it not for the emotional attachment to the home, Medicaid recoveries from the value of the home in the decedent's (or community spouse's) estate would probably be considered "fair" by a broader spectrum of the population than is currently the case. For many people, however, especially single Medicaid nursing home clients, home equity represents a lifetime of savings. Understandably, many people would like to pass the value of their home (if not the home itself) on to their heirs. And if there is a rationale for targeting recoveries to the estates of Medicaid nursing home recipients, why are recoveries also not sought for health services provided to older clients in other programs like Medicare? Isn't the seeking of recoveries in Medicaid, a means-tested program, just another example of "picking the bones of the poor"?

These are all good questions which lack fully satisfactory answers. Nevertheless, it is important to recognize that nursing home care is fundamentally different than other types of health services. Nursing home care usually is provided in the latter stages of the life cycle and is very expensive. Considered in isolation, cost is an insufficient rationale for seeking recoveries from nursing home decedents. But when a single elderly person dies in a nursing home there are usually no dependents who require use of the economic resources remaining in the individual's estate. This is in contrast to the provision of services to younger Medicaid recipients.

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[35]Office of Inspector General, op. cit.

The fact that Medicare does not seek recoveries for health services provided to older persons stems from its different financing mechanism. In contrast to Medicaid, which is funded out of general revenues, Medicare is an insurance program. Consequently, on average, participants pay for their care through their premiums—there is no need for recoveries.

These considerations aside, it is undeniably true that most recoveries are sought from the estates of single clients with modest means. Most nursing home clients are single and, in the absence of Medicaid estate planning, have estates (excluding the home) containing a maximum of $2,000 in financial assets. For most single clients, the largest asset in their estate is the equity in their home (if they own one). In contrast, affluent single clients are only eligible for Medicaid services in the first place because they have been able to shield their assets from recovery through various Medicaid estate planning techniques.

Although it clearly seems fair to seek recovery from the estates of affluent single clients that have practiced Medicaid estate planning, the fairness of seeking recoveries from the home equity of truly poor single clients is less obvious. Even though Medicaid only recovers expenditures that it has made on the behalf of clients, Medicaid is more likely to recover from single poor clients than it is from single clients that have engaged in Medicaid estate planning, or from clients with a community spouse.

3.7 The Feasibility of Empirical Research on Medicaid Estate Planning

We are skeptical of the feasibility of designing studies that could empirically measure the magnitude of Medicaid estate planning with any degree of accuracy, or estimate the amount of savings that could be achieved if Medicaid estate planning were eliminated entirely.

First, it is difficult to establish a clear definition of Medicaid estate planning. Technically, Medicaid planning involves the divestiture or sheltering of assets *for the purpose of establishing eligibility for Medicaid*. Empirically, it is extremely difficult to establish the *intent* of asset divestiture and/or sheltering activities. For example, if a Medicaid applicant happens to spend $15,000 on a new car three months before applying for Medicaid, how do we truly know whether it was done because the applicant wanted to shelter assets, or simply because he wanted to buy a new car?

Second, there are so many ways to divest or shelter assets available to Medicaid estate planners that it would be difficult to accurately document Medicaid estate planning strategies during the pre-application period without the strong consent and cooperation of people who are participating in Medicaid estate planning activities. We are frankly skeptical of the ability of any research effort to

obtain this kind of consent and cooperation, even under assurances of confidentiality. Indeed, surveys on the financial circumstances of the elderly often yield low response rates, as well as problems with the accuracy of the data from those who do respond. The elderly, in general, do not like to reveal information about their financial circumstances.

Third, the concentration of Medicaid estate planning activity in upper middle class areas makes it difficult to design a study that could accurately adjust for the non-random prevalence of Medicaid estate planning activity across states and within states. For example, in some areas, high levels of Medicaid estate planning activity are associated simply with the location of one or more elder law practices that specialize in this area.

Consequently, we believe that Federal and state governments are better off supporting additional qualitative studies that provide quick-turnaround information about new Medicaid estate planning techniques, and the impacts of recent policy changes. These quick-turnaround studies can support the development of new policy responses to Medicaid estate planning. Front-line eligibility workers and supervisors remain the best source of information about what is going on "on the front lines" of Medicaid estate planning and efforts to maintain the means-tested nature of Medicaid long-term care benefits.

3.8 The Future of Medicaid Estate Planning

The OBRA '93 Medicaid eligibility and estate recovery provisions made a definite impact on the ability of Medicaid long-term care recipients to shelter or divest their assets, but OBRA '93 cannot be considered the final step. Medicaid estate planning is by no means dead, and it never will be, as long as Medicaid coverage of nursing home care remains a means-tested benefit. There will always be opportunities for elderly people to manage their financial assets in such as a way as to maximize the financial security of a community spouse or to preserve inheritances for heirs. The divestiture of financial assets by elderly persons is done for a large number of reasons *other than for Medicaid estate planning*, and thus, Medicaid planning strategies will simply remain one component of an elderly individual's overall estate planning strategy. In addition, as long as the incentives created by existing public policy remain as they are, it is unrealistic to believe that elderly individuals will not act in an economically rational manner. It is not fair to chastise the behavior of individuals who do Medicaid estate planning when the economic incentives for doing so are so compelling.

Eligibility workers were consistent in reporting a higher level of Medicaid estate planning activity among married applicants than among unmarried applicants. First, there is obviously a greater incentive

to preserve financial assets in the case of married applicants. Second, married couples, on average, have more wealth to protect than applicants without spouses. And third, there are more opportunities in current Medicaid eligibility provisions to pursue Medicaid estate planning in the case of married applicants. It is fair to say that the majority of eligibility workers we interviewed felt that current policy was inequitable in regard to the fairly liberal protections afforded married applicants, compared to the relatively restrictive requirement that single applicants be allowed to retain only $2,000 in total liquid assets. Further, many felt that current policy was unfair to people, who while not married, shared financial resources in their households, such as siblings who had lived together for many years, or widows and widowers who lived together but preferred not to remarry.

One future trend is fairly predictable—Medicaid eligibility provisions and estate recovery policies will become increasingly specific. Elder law attorneys readily admit that the Medicaid estate planning business depends upon the "nooks and crannies" of Medicaid eligibility policy, and that compared to the IRS code, for example, there are a lot more vagaries in Medicaid law that can be exploited to the benefit of their clientele. As the Medicaid estate planning business continues to develop and devise new Medicaid planning techniques, and Medicaid policymakers continue to respond to these techniques, we will undoubtedly see increasing specificity in Medicaid law and regulation regarding allowable versus unallowable transfers, how transfer of asset penalties are to be applied, what is and what is not a countable asset, and what mechanisms are available to states to seek recovery of assets held in the estates of deceased Medicaid recipients upon their death.

There is also a relationship between the future course of public policy regarding Medicaid estate planning and the potential growth of private long-term care insurance products. Presently, both Medicaid estate planning and private long-term care insurance (or similar risk protection products such as Continuing Care Retirement Communities) represent alternative asset protection strategies for elderly persons with substantial assets to protect. To the extent that Medicaid estate planning becomes a less viable option in the future, the demand for alternative risk protection products may increase accordingly.

Aside from the overarching issue of how liberal or restrictive Medicaid coverage of nursing home care should be, policymakers must also address issues of *fairness* and *equity*. Medicaid estate planning is often rationalized on the basis that Medicaid benefits are not only "means-tested," they are also basically "mean." The more the perception exists that public coverage of nursing home care is "unfair," the more willing people will be to circumvent the system through Medicaid planning. On the other hand, if the means-testing of Medicaid long-term care benefits was perceived as more fair, fewer applicants may feel justified in protecting their wealth through Medicaid estate planning techniques.

For example, some argue for raising the Medicaid asset threshold above the current $2,000 limit, so that single Medicaid recipients could leave *some* modest inheritance to heirs. Others have argued for a modest homestead exemption to protect homes of modest value (e.g., homes with values of $50,000) or less from estate recovery.

The policy refinements that need to be made to Medicaid statutes in order to combat the use of Medicaid estate planning techniques may seem highly technical and arcane, but their importance should not be underestimated if Medicaid is to remain a health insurance program for the truly poor.

Appendix A

CALIFORNIA CASE STUDY

Background

Medicaid expenditures for nursing home care in California are significantly below the national average. In FY 1994, total Medi-Cal payments for nursing home care in California totalled $1.9 billion. Although these expenditures are clearly substantial, only about 14.4 percent of total Medi-Cal payments in FY 1994 were for nursing home care, compared to a national average of 20.6 percent.[36] On a per capita basis, Medi-Cal spending for nursing home care is about 30 percent *below* the national average.

California has been successful in containing Medicaid expenditures for nursing home care by (1) developing alternative residential options for elderly persons who require intermediate levels of care, and (2) maximizing the use of Medicare SNF services for post-acute care. While the number of licensed nursing home beds in California per capita is significantly below the national average, California also has a large number of alternative residential care facilities (board and care homes) that serve elderly persons with minimal needs for skilled nursing care.[37] To a much larger degree than in other states, nursing homes in California are more extensively used for short-term care in the post-acute care period. Patients needing long-term intermediate care are frequently discharged from nursing homes to alternative residential facilities.

This emphasis on post-acute is also reflected in the use of Medicare-covered SNF care in California. Medicare SNF utilization and expenditures per 1,000 enrollees are significantly higher in California than the national average. Thus, while Medi-Cal spending for nursing home care represents only 7 percent of total Medicaid spending for nursing home care nationwide, California accounted for over 17 percent of total Medicare SNF payments in 1992.[38]

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[36]Source: Health Care Financing Administration, HCFA 64 data.

[37]Health Care Financing Administration. **Extramural Report: State Data Book on Long-Term Care Program and Market Characteristics**, HCFA Pub. No. 03354, August 1994.

[38]Source: Health Care Financing Administration. **Health Care Financing Review: Medicare and Medicaid Statistical Supplement**. HCFA Pub. No. 03348, February 1995.

Level of Medicaid Estate Planning Activity

Site visits were conducted to San Joaquin, Santa Clara, San Luis Obispo, Santa Barbara and Los Angeles counties. In all counties, eligibility workers were "generic" workers and were not specifically assigned to long-term care applications, except in Los Angeles county which had a separate long-term care eligibility office. In general, the level of Medicaid estate planning activity reported by eligibility workers in California was less than reported in Massachusetts or New York, and more comparable with the level of activity reported by workers in Florida. The highest level of activity was reported by workers in San Luis Obispo and Los Angeles counties.

It was interesting that although higher levels of Medicaid estate planning activity were generally reported in wealthier geographical areas in all states, workers in Santa Barbara county, one of the wealthiest counties in the entire country, were aware of almost no cases involving asset transfers in order to obtain Medicaid. Workers reported that many elderly in Santa Barbara county are so wealthy that the private cost of nursing home care is not a financial concern. In addition, many nursing home facilities in Santa Barbara are not even Medicaid-certified and do not accept Medicaid as a form of payment. Thus, if someone divests their assets and applies for Medicaid, they would have to move from the "private" facility they are in to one that accepts Medicaid. This obviously acts as a deterrent to Medicaid planning for people who want to stay in private facilities.

It is interesting to hypothesize whether the lower level of Medicaid estate planning activity reported in California could be related to the structure of the long-term care system in the state. As previously discussed, the California nursing home system uses more Medicare-covered services than other states. Thus nursing home users may be at somewhat lower financial risk for incurring "privately financed" care.

During the site visit, some respondents also claimed that nursing home users in California faced a quality incentive *not* to become eligible for Medicaid. These persons claimed that Medicaid patients receive lower quality care than private pay patients in many homes. We did not hear these same claims about quality differentials between private care and Medicaid-financed care in the other three states. However, other respondents in California claimed there was very little or no quality differential between privately financed care and Medicaid-financed care in nursing homes.

Protecting Assets Through the Use of Court Orders

Eligibility workers reported that the most common Medicaid planning technique used by married applicants was to raise the Community Spouse Resource Allowance (CSRA) through the use of court orders. Both workers and elder law attorneys agreed that it was a relatively simple process to petition the local surrogate court to set the CSRA at whatever level the couple desired (i.e., at a level equal to their total combined assets). Once the court approved the petition, the applicants would simply bring the court order with them to the local Medi-Cal eligibility office and submit it along with their application. Workers reported that current state policy offered them no alternative but to accept these court orders and allow the community spouse to retain assets at whatever level directed by the court order.

As discussed in Section 2.3.1, the use of court orders as a Medicaid estate planning technique for preserving assets for the community spouse is based upon a provision of the Medicare Catastrophic Coverage Act which clarified that assets transferred to a community spouse under a court order shall be used *in place of* the usual CSRA level in cases where such a court order exists. Thus, until there is a change in Federal law which provides clarification on the circumstances under which court orders for support of a community spouse are used in place of the usual CSRA maximums established by states, the use of this Medicaid estate planning will continue to grow in California and other states.

Protecting Assets Through Annuities

For single applicants, the simplest and most common Medicaid planning technique was to convert assets to income through the purchase of an annuity. Unlike the other states we visited, California did *not* require that an annuity be actuarially equivalent in order to exempt the annuity as a countable asset. California's eligibility regulations require only that the applicant be "receiving periodic payments of interest and principal" in order for the annuity to be considered unavailable as a countable resource. Consequently, workers reported cases in which they had to exclude annuities with very high cash values but with very low payments of income and principal. For example, as previously discussed, one office reported having to exempt as a countable resource an annuity worth over $500,000 which only made payments of principal and interest of about $5,000 annually, a rate of return of only 1 percent.

California had established this policy on annuities because the Medi-Cal Eligibility Branch believed that it could not apply transfer of asset penalties if there was no way of predicting the uncompensated value of any single annuity purchase (i.e., it was not possible to predict how long any

single annuitant would actually live and therefore how much principal would be returned to the annuitant during his or her remaining lifetime). However, with HCFA's issuance of its November 1994 Medicaid Manual transmittal (regarding some of the OBRA '93 provisions) which states that transfer of assets penalties can be applied to annuities that are not "actuarially equivalent," California now intends to change its policy on annuities to conform with HCFA's administrative guidelines. However, this change in policy regarding annuities will not take effect until California's own regulations on OBRA '93 are implemented, which is not likely to occur for some time, since many levels of review are required before new regulations can go into effect.

Transfer of Asset Penalties Not Generally Applied to Transfers of Primary Residences

California was the only state visited that generally did not apply transfer of asset penalties in cases where a primary residence has been transferred by an applicant either prior to applying for Medicaid, or after Medicaid eligibility has been established. This policy was based largely on a 1981 court case in California (*Beltran v. Myers*) which ruled that the state could not apply transfer of asset penalties on transfers of *exempt* assets. The argument of the ruling was that since a home is an exempt asset if retained by the applicant/recipient, then the transfer of a home is obviously not done for the purpose of establishing eligibility for Medicaid. The court ruled that since Federal law on asset transfers clearly state that penalties are only to be applied on transfers that have been made for the purpose of establishing Medicaid eligibility, penalties *cannot be applied* on transfers of a primary residence.

The issue then revolves around the question of whether the home is or is not an exempt asset. Federal Medicaid law is clear on the issue that a home remains an exempt asset as long as the Medicaid applicant/recipient expresses an intent to return home. One can seriously question, however, whether a home that has been transferred can retain this exemption, since it is reasonable to doubt an applicant's/recipient's intent to return home if he or she gives it away. However, legal advocates have successfully argued that it is possible for applicants/recipients to give away a home (e.g., to a son or daughter) and still have an intent to return to the home if discharged from the nursing home. Thus, if an eligibility worker encounters a case in which an applicant or recipient has transferred a primary residence, a letter from whomever has received the home stating their willingness to care for the applicant/recipient if he or she is ever discharged from the nursing home is considered sufficient documentation to maintain the home "exemption" and to prevent the application of transfer of asset penalties.

The ability of Medicaid applicants and recipients to transfer homes without penalty in California may partly explain the lower level of Medicaid estate planning activity reported by eligibility workers there, since a major objective of Medicaid estate planning in other states is to protect the primary residence for heirs. The Medi-Cal Eligibility Branch indicated that it did not believe it could change its policy in the face of *Beltran v. Myers* until there is a change in Federal law which states that transfer of asset penalties can be applied to transfers done for the purpose of establishing eligibility for Medicaid *or for the purpose avoiding estate recovery*. This change in Federal law would overcome the legal arguments used in the *Beltran v. Myers* case.

An Aggressive, But Frustrated, Estate Recovery Program

Despite the fact that California does not impose transfer of asset penalties on transfers of homes, the state nonetheless has one of the most active and developed estate recovery programs in the country. The Third Party Liability Branch of the California Department of Health Services recovered approximately $26 million in FY 1995 from the estates of deceased Medi-Cal recipients.

California law requires that any executor or administrator of an estate of a deceased Medicaid beneficiary, or anyone who is in possession of property of the beneficiary, must provide the Department of Health Services with a notice of the death, including a death certificate, no later than 90 days from the date of death. Upon receipt of such notices, the Third Party Liability Branch then has four months in which to file a creditor's claim for either the entire amount of Medi-Cal services received by the deceased Medi-Cal beneficiary after the age of 65, or for the total amount of assets in the estate, whichever is less.

In addition to receiving death notices from heirs, executor and estate administrators, the Third Party Liability Branch sends letters of inquiry to the last know address of Medi-Cal recipients whose deaths have been identified by either the Social Security Death List and/or the State Vital Statistics Death List. The letter of inquiry requests information that is used to determine if there are any assets in the estate and whether the state can legally make a claim against these assets.

As in other states, the Third Party Liability Branch in California indicated that it was difficult to obtain information about the amount of assets which may be left in the estates of deceased Medi-Cal recipients. Thus, it is often the case that the state issues a creditor's claim for the total potential liability—the total amount of Medi-Cal payments made for the deceased Medi-Cal recipient after the age of 65. The amount of the state's claim is often far in excess of the amount of assets left in the

estate, and therefore payments made in response to the claim are usually only a small percentage of the total claim.

Since Medi-Cal recipients can transfer homes without penalty in California, the Third Party Liability Branch is only able to recover real property in cases where a home has *not* been transferred and remains in the recipient's estate after death. The staff of the Third Party Liability Branch agreed that this state of affairs generally resulted in inequitable outcomes, since persons with larger estates were generally better informed and had transferred their homes prior to death, while poorer recipients were generally less well informed and were more likely to still have their homes remaining in their estates upon death. However, the Third Party Liability Branch admitted that there was nothing they could about this inequity and their job was to pursue recoveries wherever possible, regardless of whether the estate was large or small.

In June 1993, the California legislature enacted legislation authorizing the Medi-Cal program to impose liens against the property of Medicaid recipients in nursing homes who are unlikely to return home, and at the time of the site visit (June 1994) the Third Party Liability Branch was preparing to implement this new TEFRA lien program.[39] In our interviews with representatives of the Third Party Liability, staff were very aware, however, that the imposition of a TEFRA lien program would be largely ineffective if it just served as an incentive for applicants or recipients to transfer their homes prior to the placement of the lien, since no penalties would be associated with such transfers.

Subsequent to the site visit, a Federal district court also issued a ruling which required the Department, under due process laws, to give recipients (and surviving spouses) notice of its *intent* to impose a lien prior to the actual imposition of the lien itself.[40] Since such notice would simply give recipients even more opportunity to transfer their property prior to the placement of the lien, the Department decided to withhold implementation of its TEFRA lien provision for the time being.

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[39]It was also interesting that administration of the TEFRA lien program in California fell to the Third Party Liability Branch, whereas in most states, TEFRA liens are imposed as part of the normal eligibility process.

[40]*Lynn Roy Demille, et al. v. Kimberly Belshe, et al.*, No. C-94-0726-VRW.

Appendix B

FLORIDA CASE STUDY

Background

Despite a large and growing elderly population, Florida has been successful historically in containing the growth of Medicaid expenditures for nursing home care. Persons over the age of 65 comprise 18.4 percent of Florida's total population, compared to a national average of 12.7 percent. Yet Florida spends about 20 percent of its total Medicaid budget on nursing home care, which is about equal to the national average. As shown in Table 1, Medicaid spending for nursing home care *on a per capita basis* in Florida is less than half the average among all states, and Florida ranks 49th among the 50 states and the District of Columbia on Medicaid spending for nursing home care per elderly state resident.

Florida has been successful in containing Medicaid nursing home expenditures by (1) limiting the supply of nursing home beds, and (2) election of the "income cap" option for Medicaid nursing home eligibility under its state Medicaid plan. In 1992, Florida had 28.6 licensed nursing home beds per 1,000 persons over the age of 65, compared to national average of 53.1 licensed beds per 1,000 elderly.[41] Thus, the supply of nursing home beds on a per capita basis in Florida is only about half the national average. Like California, many elderly persons in Florida who require intermediate levels of care reside in alternative residential facilities, including board and care homes. In 1992, in addition to the 71,162 licensed nursing home beds in Florida, there were 61,086 other licensed residential care beds to serve elderly and disabled persons in need of 24-hour supervisory care.[42]

Florida is also one of 15 states that have elected to limit Medicaid coverage for nursing home care to persons with incomes below a "special income level" (or "income cap"). In these states, Medicaid eligibility for nursing home care is limited to individuals whose countable incomes do not exceed 300 percent of the Federal SSI benefit level for a single individual. In 1994, the Federal SSI benefit level was $446 for a single individual; thus the "income cap" in Florida in 1994 was $1,338

[41]Source: Health Care Financing Administration. **Extramural Report. State Data Book on Long-Term Care Program and Market Characteristics**, HCFA Pub. No. 03354, August 1994.

[42]Ibid.

per month. Therefore, Medicaid coverage for nursing home care in Florida was limited (for single individuals) to persons with annual incomes of less than $16,056 in 1994.

Since the average cost of private nursing home care is about $30,000 per year, the Medicaid "income cap" is often criticized for restricting access to nursing home care for persons with incomes above the "income cap" but below the private cost of nursing home care. Incapable of paying private rates, these individuals may not be able to gain access to nursing home care because they also failed to qualify for public assistance under Medicaid. Persons in this situation are often referred to as "falling in the Medicaid gap." Anecdotally, it is often said that many elderly persons who have retired to Florida, once they become at risk of needing long-term care services, migrate *back* to their state of origin so (a) they can be closer to their children and (b) they can gain access to public long-term care services.

Level of Medicaid Estate Planning Activity

Local site visits were conducted to Palm Beach, Dade, Sarasota, and Pinellas counties. In several counties, interviews were conducted at more than one eligibility office within the county.

In most of the offices we visited, workers reported relatively low levels of Medicaid planning. This was primarily related to the fact that the elderly population served by most of the offices was relatively poor. Workers in these offices reported that most applicants did not have many financial assets to begin with. However, two eligibility offices, one in Delray Beach and one in Sarasota, reported high levels of Medicaid planning activity. These offices were located in areas where there was a relatively large population of upper middle class elderly. Thus, the site visits in Florida corroborated our finding in other states—there is more Medicaid estate planning activity in wealthier geographical areas.

Impact of OBRA '93 on Transfers Through Joint Bank Accounts

Workers in all offices indicated that a common Medicaid planning technique prior to OBRA '93 was the transfer of funds through joint bank accounts. This technique was remarkably simple. A prospective Medicaid applicant could simply add a joint signatory (e.g., a son or daughter) to his or her savings account, and then have the joint signatory withdraw all of the funds at a later date. The argument made in these cases was that under Florida state banking laws, all joint tenants on a bank account have a 100% ownership interest in the assets held in the account. Thus, a joint signatory has equal ownership rights to the assets held in the account as the Medicaid applicant, and the withdrawal

of funds from the account by a joint tenant cannot legally be considered a "transfer." Elder law attorneys also cited a 1986 letter from HCFA which they claimed prohibited the state from applying transfer of asset penalties to such cases. However, the letter dealt with a case involving the withdrawal of funds from a joint account by an ineligible spouse prior to the enactment of the Medicaid spousal impoverishment provisions under MCCA, which made significant changes to Medicaid eligibility rules for Medicaid nursing home applicants who are married.

One of the provisions of OBRA '93, however, specifically addressed this issue; clarifying that *any* withdrawals from joint accounts that reduced the applicant's control or ownership over the assets in the account are to be treated as transfers subject to penalty. Thus, upon the enactment of OBRA '93, Florida quickly implemented this specific provision of OBRA '93 in its own regulatory policies, and eligibility workers reported that this change had made a definite impact on eliminating this Medicaid planning technique in Florida.

Qualified Income Trusts

As an income cap state, Florida is one of the 15 states that are affected by the Qualified Income Trust provisions of OBRA '93. This provision essentially enables individuals who are denied Medicaid eligibility because they have incomes over the "income cap" to become eligible for Medicaid by temporarily transferring their income into a so-called "income trust." In fact, this provision acts almost like a Congressional mandate on "income cap" states to implement a medically needy program for nursing home coverage, since the income trust provision works operationally much like a medically needy program. The main difference is that the OBRA '93 Qualified Income Trust provision requires applicants to establish an income trust as a means for gaining accessing to Medicaid benefits for which they would otherwise not qualify.

Upon the enactment of OBRA '93, local and state Medicaid eligibility offices immediately began receiving inquiries from elder law attorneys about how Florida was going to regulate Qualified Income Trusts and when implementing regulations were going to be issued. Applications with Qualified Income Trusts were left pending in local eligibility offices until the state could receive administrative guidance from HCFA and issue instructions to the local eligibility offices. These instructions were first issued in June of 1994, and then revised several times thereafter.

Essentially, Florida's Qualified Income Trust provisions allow applicants to establish an income trust as a "shell." Income is transferred into the trust prior to submission of the Medicaid application. If approved, *all* of the income in the trust must then be used as the recipient's contribution to the cost

of his or her nursing home care, except for the recipient's personal needs allowance and any allowable contributions to the community spouse.

At the time of the site visit, Florida indicated that there about 1,000 income trusts either approved or pending. While many state and local officials we interviewed agreed that the whole Qualified Income Trust (QIT) provision was basically a "shell game" that temporarily moves an applicant's income around simply to establish Medicaid eligibility, most were generally supportive of the policy intent of the QIT provision. Being in an income cap state, Medicaid staff in Florida had witnessed the plight of many elderly individuals who were stuck in the situation of having income in excess of the Medicaid eligibility threshold, but below the private cost of nursing home care.

Efforts to Expand the Estate Recovery Program

At the time of the site visit to Florida in August of 1994, Florida had a relatively weak estate recovery program but was in the stages of planning for greatly expanding its estate recovery efforts. In August of 1994, Florida's entire estate recovery program consisted of a contingency contract with one attorney to pursue estate recoveries across the entire state. Local county eligibility offices were supposed to inform the state Office of Third Party Liability of all deaths of Medicaid recipients through the submission of HRS Form 325, but compliance by many counties was half-hearted at best. Many of the more populated counties were not submitting the forms at all.

Another problem in Florida's estate recovery program was in obtaining timely information from the Medicaid Third Party Recovery Unit on the amount of the state's claim (incurred Medicaid costs subject to recovery). Due to other data processing priorities, delays occurred in extracting data from the state's MMIS system on the amount of the state's claim for a requested case. Once the amount of the state's claim was obtained from the data processing unit, it was then up to the contracted attorney to determine whether there were any funds in the deceased recipient's estate and to pursue recoveries on a case by case basis through the probate courts.

At the time of the site visit, Florida was in the process of developing a plan for enhancing its estate recovery program for consideration by the administration and the state legislature. A draft plan was submitted in September of 1994.[43]

[43]Agency for Health Care Administration, Office of Medicaid Third Party Liability. **Estate Recovery Development Plan,** September 29, 1994.

The plan recommends a greatly invigorated estate recovery effort with improved methods for identifying recent deaths, faster mechanisms to determine the state's claims, and more aggressive mechanisms to recover claims from probated estates of significant size.

Since the site visit, the Third Party Recovery Unit reports that the problem of obtaining information on recent Medicaid decedents has been greatly alleviated. Local Clerks of the Court are now routinely notifying the state of the opening of new estates.

Estate Recovery and the Exemption of the Homestead

The major issue in Florida's effort to enhance its estate recovery program was whether the state would be able to seek recovery from real property (the home) in the Medicaid recipient's estate, and, if so, whether the state could impose a TEFRA lien on a recipient's home to protect its claim while the recipient was still alive. The barrier to recovery of real property was Florida's own state constitution which contains a very explicit "homestead exemption."[44] The exemption protects an individual's homestead from virtually all creditors, and prevents the placement of liens, other than voluntary liens such as mortgages, on homesteads by creditors. Florida's Supreme Court has ruled that the homestead generally passes to heirs free from the claim on any outside creditors to a decedent's estate.

During the development of its plan to expand its estate recovery program, the Medicaid Third Party Recovery Unit researched the subject and history of the homestead exemption in Florida and elicited the assistance of the state Attorney General's Office for it's legal opinion on whether the state could recover homestead property without an outright amendment to the state constitution. The Attorney General's office concluded that without an amendment to the state constitution the Agency could not file liens (voluntary or involuntary) against homestead property and could only seek recovery in cases where the property had lost its homestead character.

An amendment to the Florida Constitution can only be adopted by a three-fifths vote of the membership of each house of the legislature or by petition from the populace and passed by a majority vote of the citizens. The staff of the Third Party Recovery Unit felt that such an amendment to the state constitution had no chance of passage. Thus, the only cases in which the state will seek

[44]Constitution of the State of Florida, Article X, Section 4. Homestead; exemptions.

recovery from real property under its estate recovery program will be cases where it petitions the courts to determine the applicability of the homestead exemption on a case by case basis when Agency staff believe that the property may have lost its homestead character.

Appendix C

MASSACHUSETTS CASE STUDY

Background

Massachusetts is known as one of the "birthplaces" of the Medicaid estate planning industry. Much of the literature that has written on Medicaid estate planning strategies has been written by elder law attorneys from the Boston area, and state Medicaid officials confirmed that there are a number of Medicaid planning attorneys who have developed quite sophisticated techniques through many years of experience. This is one reason why Massachusetts was selected as one of the four case study states. Additionally, the magnitude of Medicaid estate planning was reported to be high in Massachusetts due to its relatively affluent older population and the high costs of nursing home care in the state.

Medicaid expenditures for nursing home care in Massachusetts are higher than the national average. In 1992, Massachusetts had 63.3 nursing home beds per 1,000 elderly persons—considerably higher than Florida (28.6), California (40.3), or New York (44.7), and also higher than the national average of 53.1 beds per 1,000 elderly. In addition, average reimbursement rates for Medicaid coverage in Massachusetts ($96/day) were high relative to California ($73/day), Florida ($77/day) and the national average ($75/day)—although they were less than Medicaid rates in New York state ($123/day). Not surprisingly, given higher reimbursement rates, the average annual Medicaid payments per nursing home recipient were also higher in Massachusetts ($22,299) and New York ($31,199) relative to California ($13,889), Florida ($8,898), and the national average ($14,889).[1]

Massachusetts also had the highest 1989 per-capita income of the four states ($17,224), followed by New York ($16,501), California ($16,409), and Florida ($14,698); the national average was $14,420. Florida, of course, had the highest elderly population percentage in 1992 (18.4%), followed by Massachusetts (13.9%), New York (13.1%), and California (10.5%). The elderly population percentage for the entire nation was 12.7 percent. Finally, all of the states were highly urbanized relative to the U.S. metropolitan population percentage of 79.4 percent. California had the

[1]Brian O. Burwell and William H. Crown. 1994. **Public Financing of Long-Term Care: Federal and State Roles**. The MEDSTAT Group, Cambridge, MA (September).

highest metropolitan population percentage (96.8%), followed by Massachusetts (96.2%), Florida (92.9%), and New York (91.8%).

In addition to its nursing home market and demographic characteristics, Massachusetts differed from the other three case study states in that it operated only three eligibility offices for Medicaid long-term care services. We were interested in studying whether the "tightness" or "looseness" of Medicaid nursing home eligibility procedures were related to specialization of eligibility workers in long-term care applications—particularly given the highly technical knowledge about various types of financial instruments (e.g., trusts, annuities, retirement plans, pensions, etc.) that is often required in reviewing applications for Medicaid nursing home coverage.

Finally, Massachusetts was known to have taken several steps in the late 1990s to tighten Medicaid nursing home eligibility and strengthen its estate recovery efforts. For example, at the time of our site visit, Massachusetts was the only one of the four case study states to uniformly place liens on the real property of Medicaid recipients in nursing homes.[2]

Case Study Methodology

Our site visit to Massachusetts took place in December of 1993. The "visit" was actually a series of visits to several state offices and to each of the three long-term care eligibility offices. We began by interviewing state officials in Medicaid Eligibility Operations, legal staff in the Department of Public Welfare, and staff in the Medicaid Estate Recovery Unit. The purpose of these visits was to gain an understanding of the state perspective on Medicaid estate planning policy issues.

Following interviews with state-level staff, interviews were conducted at each of the three long-term care eligibility offices. As indicated earlier, Massachusetts differed from the other case study states in having separate eligibility offices for Medicaid nursing home services. Each of the three offices serves a region of the state. The Springfield office handles applications in the western portion of the state. The Taunton office serves the southeastern portion, and the Charlestown office serves the northeastern portion (including the Boston metropolitan area).

Individual eligibility staff members were the key focus of the interviews. Front-line eligibility workers were in the best position to judge the extent and forms of Medicaid estate planning, since they

[2]New York used TEFRA liens at the discretion of the counties.

are the ones who process applications every day. Several eligibility workers were interviewed at each site. In Taunton, we interviewed the director of the office, an eligibility worker supervisor, four eligibility workers, and one redetermination worker. In Springfield, we interviewed the office director, two eligibility work supervisors, and three eligibility workers. Finally, in Charlestown, we interviewed the director, two eligibility worker supervisors, and three eligibility workers.

The workers interviewed in all three offices in Massachusetts were, on balance, quite sophisticated in their knowledge of Medicaid estate planning techniques and seemed more highly trained than eligibility workers interviewed in the other three states. This suggests that specialization in long-term care applications enables eligibility workers to attain a higher level of expertise than is possible for generic eligibility workers in other states. Even though the other three states all had at least one or more offices that specialized in long-term care applications, the establishment of an entirely separate long-term care eligibility division in Massachusetts clearly had contributed to the high level of expertise evidenced by the workers we interviewed.

Overview of Findings

Estimates of the prevalence of Medicaid estate planning given by eligibility workers ranged from "no more than 2 percent" to 75 percent of all long-term care applicants. These estimates were the extremes, however; the majority of workers estimated that between 20 to 33 percent of all applicants had done some Medicaid planning prior to the date of application. Workers also reported that the practice of Medicaid estate planning had definitely increased over time—particularly following implementation of the spousal impoverishment provisions in the Medicare Catastrophic Care Act of 1988. Consistent with this observation, workers reported that Medicaid estate planning was more common in applications involving a community spouse (generally estimated to be 15 to 33 percent of cases, depending upon the worker and site).

Eligibility workers reported that Medicaid estate planning involved a variety of techniques including trusts, the "half a loaf" method, annuities, spousal refusal, and using the fair hearing process to raise the community spouse resource allowance (CSRA) level. However, workers also reported a virtual halt in the use of trusts following the passage of OBRA 93.

The variety of techniques observed in Medicaid nursing home applications no doubt influenced worker estimates of the prevalence of Medicaid estate planning. For example, some workers might view increased spending during the pre-application period to be evidence of Medicaid estate planning

while others might not. Such gray areas in defining Medicaid estate planning make it difficult to assign hard numbers estimating its magnitude. On the other hand, other techniques are more clearly evidence of Medicaid estate planning. A good example of the latter is the use of the fair hearing process to raise the CSRA level in order to allow the community spouse to retain a higher level of assets.

Raising the CSRA through Fair Hearings

Raising the CSRA through the fair hearing process is one of several Medicaid estate planning techniques that stem from the spousal impoverishment provisions of the Medicare Catastrophic Care Act (MCCA) of 1988. Under the provisions of the MCCA, jointly held financial assets are totalled, then divided equally between the institutionalized spouse and the community spouse when determining eligibility for Medicaid nursing home coverage. One half of the assets are considered to belong to each spouse, and the community spouse is allowed to retain his or her half, subject to both a minimum and maximum amount.[3] At their option, states can also set the *minimum* amount retained (called the Community Spouse Resource Allowance, or CSRA) anywhere between the established Federal minimum and maximum. Both the minimum and maximum CSRA levels are increased each year in accordance with inflation.[4] In Massachusetts, the CSRA level is set at the established Federal minimum, which at the time of our site visit in 1994 was $14,532.

The Medicaid spousal impoverishment provisions also established Federal rules for protecting the income level of community spouse. These provisions were designed to ensure that the community spouse would retain an adequate level of income on which to live. Like the CSRA, the MMMNA is subject to both a Federal minimum and a maximum.[5] If the community spouse's income is below the MMMNA, language in MCCA states that the community spouse can receive additional income and/or resources from the institutionalized spouse to bring her income up to the MMMNA.[6]

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[3]In 1995, the minimum amount of assets which the community spouse is allowed to retain (even if it equals more than half of the couple's total assets) is $14,964. The maximum amount (even if it is less than half) is $74,820.

[4]For a summary of Medicaid eligibility for nursing home coverage see Crown, W., Burwell, B., and Alecxih, L. 1994. *An Analysis of Asset Testing for Nursing Home Benefits*. Washington, D.C.: American Association of Retired Persons, Public Policy Institute.

[5]In January 1995, the minimum MMMNA was $1,230 per month (150 percent of the Federal poverty level for a couple) and the maximum was $1,870.50 per month. Note that if the community spouse's income is in *excess* of the MMMNA, the community spouse is *not* required to contribute to the cost of care for the institutional spouse beyond the first month of institutionalization. Thus, while the assets of a married couple are treated jointly in determining eligibility for the institutionalized spouse, income is still treated separately.

[6]For a more detailed explanation of this provision, see Burwell, B. 1991. *Medicaid Estate Planning for Long-Term Care Coverage*. Cambridge, MA: SysteMetrics, pp. 22-23.

Through a fair hearing process, the community spouse can also have the CSRA raised *above* the state's CSRA maximum to the asset level that is necessary to produce enough income to bring the community spouse's income up to the MMMNA.

Eligibility workers reported that, with low interest rates, community spouses were often able to retain assets in excess of $200,000 by using the fair hearing process to raise the CSRA. Although nearly all of the workers felt that the spousal impoverisnment provisions of MCCA were a good idea, most felt that the process of raising the CSRA level in fair hearings often allowed the community spouse to retain an excessive level of assets. Eligibility workers also expressed frustration that the fair hearing process made them look like the "bad guys." Under Massachusetts Medicaid eligibility rules, workers had no choice but to deny Medicaid nursing home eligibility to applicants having a spouse with assets greater than the CSRA maximum—even though they knew that this decision would often be overturned in the fair hearing. In 1993, the three long-term care eligibility offices reported about five to fifteen fair hearing appeals were held each month to increase the CSRA above the federal maximum of $70,740.

The "Income First" Rule

The raising of the CSRA through fair hearing appeals was a particularly attractive strategy because Massachusetts at the time was not using the so-called "income first" rule. The "income first" rule has to do with whether the income of the institutionalized spouse is looked to as the *first* source for raising the income of the community spouse up to the MMMNA, prior to raising the CSRA. At the time of site visit, this was not the case. Rather, the income of the institutionalized spouse was *not* being diverted to the community spouse, and in fair hearing appeals, only the income of the community spouse was being taken into account in decisions about raising the CSRA above the Federal maximum.

However, Massachusetts was in the process of changing its Medicaid eligibility regulations to adopt the "income first" rule. Massachusetts' decision to change its policy was further supported by HCFA in March of 1994, when the Medicaid Bureau issued a memorandum which stated that the language in MCCA was not specific on the "income first" rule. As a result, HCFA stated in the memorandum, states were free to adopt their own reasonable interpretations of MCCA on this issue:

> ...We would now like to clarify that states have the option to use the "income first" rule or to apply some other reasonable interpretation of the law until we have issued final regulations which specifically address this issue[7]...

Massachusetts issued its new regulations implementing the "income first" rule in June of 1994. As a result of this policy change, the income from the institutionalized spouse (except for the personal needs allowance) is now diverted to the community spouse *before* the CSRA can be raised through a fair hearing appeal.[8] In a follow-up interview, the Medicaid program office reported that after the implementation of the "income first" rule, the number of fair hearing appeals to raise the CSRA declined significantly.

However, the "income first" rule remains controversial. In other states where the "income first" rule has been applied, the issue is being contested in the courts. In a series of court cases in Ohio, the state initially won a case that determined that the state had the right to apply the income first rule, but two more recent appeals court decisions have ruled that MCCA is "unambiguous" on this issue, and that the statute calls for increasing the MMMNA through a raising of the CSRA level first, before looking to the institutionalized spouse's income.[9] There is also a Federal class action suit pending in the state of Pennsylvania contesting that the state was not providing applicants with any information regarding their rights to seek an increase in the MMMNA by raising the CSRA above the Federal maximum.[10]

The argument for raising the CSRA of the community spouse *without* looking first to the income from the institutionalized spouse stems from the potentially transitory nature of the institutionalized spouse's income. Elder law attorneys argue that it is important to allow the community spouse to retain enough assets to enable her to support herself if and when the institutionalized spouse dies. Although this argument has merit, it is important to assess the degree

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[7]Memorandum from Sally K. Richardson, Director, Medicaid Bureau, HCFA to All Regional Administrators, March 3, 1994.

[8]130 CHR: Division of Medical Assistance, 505.190 Rev. 6/3/94.

[9]See *Kimnach v. Ohio Department of Human Services* (Ct. of Common Pleas, Franklin County, No. 93CVF-06-4191, February 14, 1994); *Kimnach v. Ohio Department of Human Services* (Ohio Ct. App., Franklin County, No. 93APE04-520, 1994 WL 484660, September 8, 1994); and *Gruber V. Ohio Dept. of Human Services* (Ohio App. Ct., No. 94CAE06015, 1994, WL 667869, October 28, 1994). These cases are also summarized in **The ElderLaw Report**, Volume VI, Number 1 (July/August 1994) Number 3 (October 1994) and Number 6 (January 1995).

[10]See Coughlin, Kenneth M. "Class Action Suit Challenges Pennsylvania's 'Income First' Rule." **The ElderLaw Report**, Volume VI, Number 1, July/August 1994.

to which the institutionalized spouse's income is, in fact, transitory. For example, spousal benefits under Social Security will continue to be paid following the death of the institutionalized spouse, as will survivors benefits from private pensions. Some income sources, such as life insurance, may become available *only* upon the death of the institutionalized spouse.

Other Medicaid Planning Techniques

The Medicaid estate planning business is well developed in Massachusetts, and eligibility workers reported that a number of attorneys have employed very sophisticated techniques to shelter assets for their clients. However, the use of any single technique was not widespread. In addition to the more common strategies, such as the "half a loaf" method and raising the CSRA through fair hearing appeals, workers reported occasional use of the "just say no" strategy, the sheltering of assets in revenue-producing business property, and the construction of new forms of Medicaid trusts. One example of the latter was a life estate with "super-added" retained powers. The argument of the Medicaid planning attorneys who crafted these life estate trusts is that the "super-added" powers of these instruments decrease the value of the assets "transferred" under the life estate, and therefore reduces the length of the penalty period.

Massachusetts was the only state in which workers reported that applicants occasionally appealed transfer of asset penalties on the basis that the transfer had not been made with the purpose of establishing eligibility for Medicaid, and applicants had sometimes won these fair hearing appeals.

Massachusetts was also the only state visited in which some workers were fairly "strict" in applying transfer of asset penalties in situations where non-exempt assets were being converted to exempt assets. For example, if a number of major purchases had been made just prior to the submission of the Medicaid application that were inconsistent with the applicant's usual lifestyle (e.g. an expensive car, art, expensive presents for family members) some workers ruled such purchases as transfers subject to penalty.

Estate Recovery in Massachusetts

Massachusetts' estate recovery program has undergone major changes in the past few years and, of the four case study states, Massachusetts' estate recovery program was the most effective and comprehensive. Between 1991 and 1995, estate recoveries increased from $7.7 million to an

estimated $14 million, an increase of 82 percent.[11] About 90 percent of the recoveries come from real estate property in recipients' estates, with the remaining 10 percent accruing from court settlements, assets remaining in personal accounts, and miscellaneous other sources. The estate recovery program is centralized in the Office of Benefit Coordination and Recoveries in the Division of Medical Assistance in Boston, which in FY 1995, employs 6.5 estate recovery staff, with additional support from legal staff of the umbrella human services agency.

Prior to 1990, estate recovery in Massachusetts was characterized as "haphazard," and depended largely upon referrals by local eligibility workers to the central estate recovery unit. In order to increase the effectiveness of its estate recovery program, the Massachusetts state legislature initially enacted legislation in 1990 to place an *automatic lien* on *all* probated estates in Massachusetts, regardless of whether the estate was that of a Medicaid recipient or not. The automatic lien provision was never implemented. It became apparent that the administration of the automatic lien provision would be extremely burdensome on both the state and the probate courts. Although the state's claim on the probated estates of deceased Medicaid recipients would be protected, the law required the state to release liens on the greater majority of estates of people who had *not* been on Medicaid. The law would also have tied up the ability of the probate courts to issues licenses to sell real estate while estates were being settled. Thus, the law was amended several times to delay the implementation date of the automatic lien provision, and a Special Commission was established to review the law and recommend alternatives. The Special Commission issued its report in November 1991.[12]

The Special Commission recommended that the automatic lien law be repealed, and made a series of recommendations for alternative legislative approaches. All of the Commission's recommendations were enacted into law on July 1, 1992, and this legislation basically provides the construct for the state's current estate recovery program. The foundation of the program is a legislative requirement that executors of *all* probated estates notify the Division of Medical Assistance (DMA) when a deceased individual's estate is probated, regardless of whether the individual was a Medicaid recipient or not. The petitioner is required to send a copy of the death certificate and a copy of the petition by certified mail to DMA. Since the death certificate includes the decedent's Social Security number, DMA then conducts a match between death certificates and its Medicaid eligibility

[11] In comparison, Massachusetts' Medicaid payments for nursing home care increased only 7 percent from 1991 to 1994.

[12] *Special Commission on Estate Recovery: Report and Proposed Legislation*, November 1991.

files to determine whether the decedent was a Medicaid recipient, and, if so, calculates the total Medicaid payments made on the person's behalf beyond the age of 65. In 1994, there were about 26,000 probated estates in Massachusetts, and of these, about 2,000 had a Medicaid claim against the estate (although many estates have no assets available for recovery).

The state's claim on probated estates is made either through a "Notice of Claim" that is filed in the probate court (known as the "informal method") or through the filing of a civil suit in probate court within one year of the recipient's date of death (known as the "formal" method). Most of the state's recoveries, about 85%, are made through the informal "Notice of Claim" method. The "formal" method is used primarily in cases where heirs protest the state's Notice of Claim, and the state's right to recovery must be pursued through a civil suit.

The 1992 enabling legislation also enhanced the state's position as a priority creditor in instances where there are multiple creditors against the estate. Under the new law, only costs of estate administration, funeral expenses, unpaid medical bills, federal taxes, and other specified taxes take precedent over DMA's claim (however, the state's claim takes precedence over back property taxes). The estate recovery unit indicated that generally about the first $10,000 of an estate is not recoverable, due to administrative fees and burial costs. It usually takes the Department nine months after the death of a Medicaid recipient to settle a claim and the average amount recovered is about $20,000.

Through another process, the Estate Recovery Unit has methods to identify Medicaid recipients who have recently died. This process identifies deceased Medicaid recipients who do *not* have probated estates. If the Department does not receive notice of petition to probate for these persons after a period of time, the 1992 legislation allows the Department to petition the probate court to appoint a public administrator to probate the estate. In addition, the law allows the Division to designate a voluntary administrator for estates with assets (excluding real estate) valued at less than $15,000. In these cases, DMA actively pursues family members to inquire about the status of estate administration. In cases where there are no apparent family heirs, DMA also can recover from bank account balances maintained by nursing facilities on behalf of recipients.[13] Only a small amount of recoveries are achieved through these other methods, however, since estates that are not probated usually have few or no assets.

[13]Since Medicaid eligibility requires recipients to have less than $2,000 in liquid assets, these account balances tend to be very low, consisting of deposits of recipients' personal needs allowances.

Once the heirs to the estate receive a "Notice of Claim," they have 60 days to file a protest with the state. DMA indicated that about 25 percent of all estate recovery cases are protested, and in these cases, DMA receives legal support from its umbrella agency on contested cases. However, the state reported that there is considerably more acceptance by families of the state's claim against the estate, partly because most claims involve settlement of a lien that has been placed on the recipient's real property, and families have been made aware of the state's lien since the point of initial Medicaid eligibility (see below).

Pursuit of Deferred Claims

At the time of our site visit, Massachusetts was just beginning to pursue recoveries in cases where recovery is required to be deferred under Federal law (i.e., when there is a surviving spouse, disabled child, or child under age 21, and/or when there is some other exempt relative still living in the decedent's home). Although no liens may be imposed upon the property of surviving relatives, the state's claim for recovery on property that passes to heirs remains valid. The state had also initiated a program that allows heirs to pay off the state's claim up front, at a discount, rather than wait for the state to recover from the estates of surviving relatives. This program relieves the state from tracking deferred claims over the remaining lifetimes of relatives.

Liens on Property

As a further protection of the state's claim on the property of Medicaid recipients, both during their lifetime and after they die, Massachusetts implemented a lien program on homes in July of 1991. At the point of initial eligibility, workers determine whether applicants own homes, and whether there are any relatives living in the home that would preclude the placement of a lien under Federal law.[14] A lien is also not placed on the home if there is certification by a medical authority that the recipient is likely to return home within six months. In addition, if the recipient returns home or loses Medicaid eligibility, then the lien is released.

[14]Under Federal law, states may not impose liens on property in which any of the following persons reside: a spouse, a sibling with an equity interest who has lived in the home for at least one prior to the applicant's nursing home admission, a permanently and totally disabled child, a blind child, or a child under the age of 21.

Exemption for Purchasers of Long-Term Care Insurance

Although Massachusetts is not a participant in the Robert Wood Johnson Partnershio Program for Long Term Care, and therefore does not directly subsidize the purchase of long-term care policies, the state still has a small provision to encourage the purchase of private long-term care insurance. If a Medicaid recipient had private long-term care insurance coverage that met the requirements of the regulations of the Massachusetts Division of Insurance, but still was forced to go on Medicaid after their private insurance benefits were exhausted, the state will make no recovery from their estate upon death.

Ongoing Issues in Massachusetts' Estate Recovery Program

Recovery staff reported four remaining problems with the current estate recovery program. First, the Department may fail to recover on property that does not pass to heirs through probate. These can be homes that are jointly owned, homes placed in trusts, and homes placed in life estates.[15] These situations often involve cases where a lien cannot be placed on the property due to the fact that an exempt relative still lives in the home. Thus, although the state still has a legal claim on the recipient's ownership interests in such property upon the recipient's death, the fact that (a) no lien has been placed on the home, and (b) the property passes to heirs outside of the probate process, makes it unlikely that the state will be able to make a recovery in these kinds of cases. Interview respondents reported that they had no idea to what extent property held by Medicaid recipients passes to heirs unnoticed through these kinds of financial instruments.

The second problem with the current estate recovery program relates to the state's "window of opportunity" for filing the "Notice of Claim" in the local probate court. Although the recovery unit is notified by the estate executor of an initial petition for probate, it is *not* notified of when the estate is actually scheduled to come up for probate. Under current law, the state is required to file its "Notice of Claim" in probate court within four months of approval of the official bond of the executor or administrator. However, the state has no way of knowing when the approval of the official bond has been made, other than by continually checking with the probate courts. Since the probate courts are backlogged, the state cannot predict when estates are likely to be probated. As a result, Medicaid staff must physically visit the probate courts and look at dockets to see when various cases are

[15]Legislation was proposed by the state to expand the definition of the estate beyond the probated estate in an effort to deal with this problem but it was not passed by the 1995 state legislature.

scheduled for probate. Once the state knows the schedule for a particular estate, it must submit its claim to the court directly. If the state does not make its claim within the four-month window, the legal division has one year to seek recovery through the formal method of filing a civil action. Estate recovery staff said the process of checking on schedules with the local probate courts was time consuming, and constituted a large percentage of the costs of administering the program.

A third problem is that families sometimes take Medicaid recipients off of Medicaid just prior to death in order to avoid estate recovery. Although the state still has a right to seek recovery for costs incurred while the recipient was on Medicaid, estate recovery staff admitted that the system is not fool proof in identifying recipients who were once on Medicaid, but whose eligibility was terminated prior to death. Liens on property must also be dissolved if a recipient goes off Medicaid, so that it is easier for families to transfer or sell the house before recovery can occur.

A final problem is that families sometimes cannot settle their claim with the state until they sell the house, and they cannot sell the house until the state releases the lien. Ideally, the state informs the heirs (and other parties in the proposed sale of the property) that the lien will be released upon the sale of the property and the family's settlement of the claim. However, the state admitted that less than efficient communications about the release of liens in such cases sometimes impedes the ability of families to close sales on property, which understandably cause some families to become upset. The state admitted that it need to improve procedures for releasing liens expeditiously in these kinds of situations.

The House as a Countable Asset

In 1991, Massachusetts tried to revise its Medicaid regulations to include the home as a countable asset in cases where there was little likelihood that a Medicaid recipient would ever return home. Regulations were promulgated to require all Medicaid recipients or applicants in nursing homes to obtain a doctor's certification regarding the likelihood of returning home within the following six months. In the absence of such a certification, the recipient or applicant would be given nine months to sell the home, after which the owner would be required to accept any offer for the home greater than two-thirds of its assessed value. However, HCFA disallowed this policy change on the basis that

Massachusetts's criteria on exclusion of the home was more restrictive than SSI eligibility rules, and the new policy was never implemented.[16]

Pilot Program to Identify Unreported Properties

At the time of the site visit, the state was undertaking a pilot program at its Springfield office to identify real estate holdings of applicants or recipients that might have been previously unreported. The office had bought a subscription to a real estate on-line inquiry program that provided the office with data on all real estate transactions over $1,000 in the local area. Over the first three months of operation, the office had identified information from the on-line program on four cases involving applicants or recipients that differed from information provided on applications, and was further investigating those cases. The cost of the on-line program was approximately $300 per month, and therefore the pilot program was considered cost-effective. A shortcoming of the program was that it only identified parties in real estate transactions by name, so matching common names with Medicaid applicants/recipients required additional manpower.

Discussion

Massachusetts was clearly distinguished from the other three states selected for this study in that it is a both a state that has a *very* well developed, aggressive, and sophisticated Medicaid estate planning industry, but also a state where the growth of Medicaid estate planning has led to a strong policy response from the state administration to redress its potential impacts. Recognizing that Medicaid estate planning, if not checked, could increase the growth of Medicaid expenditures, both the legislature and the administration have made a strong policy statement of their intent to keep Medicaid a means-tested program for people who truly need public assistance. In the past few years, the state had initiated a lien program, significantly strengthened its estate recovery program, implemented the "income first" rule, and had attempted to implement a new policy for counting the home as an available asset in cases where there was no objective evidence that the recipient would be discharged home. Further, unlike the other three states we visited, it was much more apparent that long-term care eligibility workers felt it was their personal and professional responsibility to identify and deter Medicaid estate planning practices, where allowable under the law, and to preserve Medicaid for the truly poor. While several workers reported that they felt like were fighting a "losing battle," this

[16]Massachusetts is a so-called "1634" state which follows SSI rules in determining eligibility for the aged, blind, and disabled. In 1634 states, SSI regulations regarding exclusion of the home as a countable asset in eligibility determinations must be followed for SSI-related Medicaid applicants and recipients.

sense of mission by front-line workers was clearly not as evident in the other three states selected for the study.

The marginal impacts of OBRA '93 itself on Medicaid estate planning activities in Massachusetts is difficult to judge. Probably the greatest impact of OBRA '93 in Massachusetts will be on the use of trusts as Medicaid planning devices. Eligibility workers reported that the percentage of applications involving trusts or annuities dropped off dramatically following the passage of OBRA 93. At an elder law conference held in Boston dealing with the Medicaid estate planning provisions of OBRA 93, elder law attorneys were pessimistic about the ability to continue using trusts and annuities as Medicaid estate planning tools.[17] Part of this hesitancy was due to the uncertainty about how trusts and annuities would be treated in eligibility determinations. Although some of the uncertainty has since been removed by clarifications from HCFA, the OBRA 93 provisions are restrictive enough to reduce the use of trusts and annuities as Medicaid estate planning tools in the future.

The restrictions on trusts as Medicaid planning tools could possibly have the added impact of discouraging more attorneys from specializing in Medicaid estate planning. We interviewed one elder law attorney who had built a large practice around Medicaid estate planning and who said that, as a result of OBRA 93, the use of trusts (with the possible exception of income-only trusts) for Medicaid estate planning was "basically dead." He also felt that OBRA 93 was designed by Congress to send a message to Medicaid estate planners that "we know what you are doing and we don't like it." He admitted that a large percentage of his fees emanated from writing trusts for Medicaid estate planning, and that there was little money to be made in just general counseling about Medicaid eligibility rules and methods for divesting assets. However, in his opinion, Medicaid estate planning was ethically indistinguishable from estate planning in general or income tax planning. He felt that if policymakers do not like the way people respond to various financial incentives such as attempts to preserve their estates in the face of high nursing home costs, it is up to policymakers to change the incentives.

In sum, Massachusetts can be characterized as a state in which Medicaid estate planning had grown into a significant policy problem, but due to recent policy responses, *independent of OBRA '93,* is also a state where Medicaid estate planning is on the decline. While OBRA '93 certainly helped to support the state's policy initiatives, the Massachusetts example suggests that *state policy and*

[17] Trusts, Transfers and Estate Recovery: Under the New Medicaid Law, What is a Planner to Do? Massachusetts Continuing Legal Education, Inc.: Boston, MA (September 14, 1993).

implementation is of at least equal importance to Federal policy in addressing Medicaid planning as a policy problem.

Example of Form for Using the "Just Say No" Strategy in New York State

I hereby refuse to contribute any of my income or resources toward the cost of my spouse's medical care. Please consider the income and resources of my spouse alone in determining eligibility for Medicaid, as dictated by Social Services Law Section 366.

_____
Signature

Sworn to me this

_____ day of _____, 19___

_____
Notary Public

Appendix D

NEW YORK CASE STUDY

Background

In Fiscal Year 1994, New York's Medicaid program spent $4.3 billion for nursing home care, more than twice the $1.9 billion spent by California's Medicaid program for nursing home services in the same year, *despite* the fact that there are about one million *more* elderly persons living in California than in New York.[18] On a per capita basis (expenditures per elderly state resident) Medicaid spending for nursing home care in New York is about two and a half times the national average.

New York's higher level of Medicaid spending for nursing home care is primarily attributable to differences in *price* rather than to differences in *utilization.* While the number of elderly persons receiving Medicaid-financed nursing home care relative to the total number of elderly persons enrolled in the Medicaid program is approximately the same in New York as the national average, the average cost *per recipient of nursing home care* in New York is more than twice the national average. The average Medicaid cost per nursing home recipient in New York was $33,775 in FY 1993, compared to a national average of $15,798 per nursing home recipient.[19]

In New York, Medicaid payments also account for a higher percentage of total expenditures for nursing home care across all payment sources than in other states. According to the 1987 National Medical Expenditures Survey, approximately 60 percent of all persons in nursing homes on any given day are enrolled in the Medicaid program.[20] State Medicaid officials indicated that in New York, Medicaid pays for approximately 85 percent of all nursing home days used in the state. Thus, Medicaid accounts for a larger percentage of total nursing home revenues in New York than in other states.

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[18]Source: Burwell, Brian. *Medicaid Long Term Care Expenditures in FY 1994*, Memorandum, The MEDSTAT Group, April 1995. Population data are from the Bureau of the Census, Statistical Abstract of the United States, 1994.

[19]Source: Health Care Financing Administration, Bureau of Data Management and Strategy, HCFA 20B2 data.

[20]Short, P., S. Feinleib, and P. Cunningham (1994, April). *Expenditures and sources of payment for persons in nursing and personal care homes* (AHCPR Pub. No. 94-0032). National Medical Expenditure Survey Research Findings 19, Agency for Health Care Policy and Research. Rockville, MD: Public Health Service.

State Medicaid officials in New York have been long concerned about the growth of Medicaid estate planning and its impact on Medicaid program expenditures. Relatedly, New York has been an ardent participant in the Robert Wood Johnson (RWJ) Foundation Partnership for Long Term Care. The RWJ Parternship program provides potential public subsidies (in the form of Medicaid reinsurance) to individuals who purchase Partnerhsip-approved private long-term care insurance. In the New York model of the RWJ Partnership program, individuals who purchase a minimal Partnership long term care insurance policy (defined as a policy which provides at least three years of nursing home coverage at $110 per day) do not have to spend down their assets to qualify for Medicaid after the policy's benefits are exhausted. The Partnership model used in New York state provides *higher* subsidies for private long term care insurance purchasers than other states participating in the RWJ Partnership program, partly due to the impact of high nursing home rates on the amounts involved in spenddown cases (up to $250,000 for an average length of stay), and partly due to the fact that state officials believe that higher subsidies have to be provided to potential purchasers in New York, given the ease with which it is otherwise possible to qualify for Medicaid coverage through the use of Medicaid estate planning techniques.

Data Collection

Medicaid is a state-supervised, and county-administered program in New York. Each county office of the Department of Social Services has a Medicaid program administrator who has overall operational responsibility for Medicaid eligibility operations in the county, plus limited other administrative responsibilities, including rate negotiation, licensing, and estate recovery. New York county governments also have a financial incentive to control Medicaid spending, since counties pay 20 percent of the state share (10 percent of total paymenats) of Medicaid payments for long term care.

In addition to interviews with representatives of the Division of Medical Assistance in the New York Department of Social Services (DSS), site visits were conducted to six county Departments of Social Services and the city of New York. Three counties (Monroe, Nassau, Suffolk) plus New York City were urban, densely populated area, while the remaining three counties (Delaware, Broome and Wayne) were small rural counties with much sparser populations. The variation in size and scope across these different counties must be appreciated. For example, New York City *alone* accounts for over half of Medicaid spending for nursing home care in the state, and the city spends more than 150 times what Wayne county spends for nursing home care. The four urban counties included in the site

visits all had eligibility staff who specialized in long term care applications, while the rural counties had generic staff who processed all Medicaid applications, regardless of type.

In addition to interviews with State and local DSS staff, we also conducted interviews with representatives from the New York State Department on Aging, with two elder law attorneys who had large Medicaid estate planning practices, and with a financial adviser who counseled elders on planning for their future long term care needs.

The "Just Say No" Strategy

By far the most common Medicaid planning technique reported by eligibility workers in New York was the "Just Say No" strategy. Under the "just say no" strategy, all of the assets of the institutionalized spouse (and sometimes income as well) is first transferred to the community spouse. Then, the community spouse simply "refuses" to provide any financial support to the institutionalized spouse. The Medicaid agency extends eligibility to the institutionalized spouse and decides whether or not it wishes to pursue legal action against the community spouse for failing to provide support.

The "just say no" strategy is made possible through the combination of two separate Medicaid program provisions. The first provision is a fairly long-standing provision in the Medicaid program which allows states to provide Medicaid coverage to persons who have been truly abandoned by legally responsible relatives. Historically, these cases primarily involved poor mothers and children who were abandoned by husbands/fathers. Although Medicaid eligibility rules require that the financial resources of legally responsible relatives (spouses and parents of children under the age of 18) are deemed available to Medicaid applicants in determining eligibility for Medicaid, this provision recognized that it was not fair to deny eligibility to a poor mother who did not have access to the financial resources of her husband due to financial abandonment. In New York, this provision is recognized in State Social Services Law 366(3), which states in part:

> Medical Assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative

> in accordance with title six of the article three and other applicable provisions of the law.

The second Medicaid program provision which makes the "just say no" strategy possible is the spousal impoverishments provisions of the Medicare Catastrophic Coverage Act of 1988. The spousal impoverishment provisions allow married applicants for nursing home services to transfer all of their assets between them without penalty, since another part of MCCA provides that the *combined* assets of both spouses are to be considered available in determining eligibility for the institutionalized spouse.[21] Thus, the MCCA spousal impoverishment provisions created a situation in which a Medicaid applicant could transfer his or her assets *without penalty*, while the prior Medicaid program provision on spousal abandonment allowed one spouse to refuse financial support to the other spouse without impairing the eligibility of the "abandoned" spouse.

It is reasonable to assume that the architects of the Medicaid spousal impoverishment provisions did not consider the possibility that one spouse might refuse to provide financial support to the other without impairing the Medicaid eligibility of the "unsupported" spouse, or that the new spousal impoverishment provisions might lead to the utilization of the "just say no" strategy. Elder law attorneys often disagree, pointing to still another provision of the Medicare Catastrophic Coverage Act, which states:

> The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where--
> "(A) the institutionalized spouse has assigned to the state any rights to support from the community spouse;" [Sec. 1924(c)(3)]

Elder law attorneys suggest that the inclusion of this section implies that it was the intent of Congress to explicitly require states to provide Medicaid eligibility in cases where a community spouse has elected not to provide financial support to the institutionalized spouse. Attorneys have also argued that the "just say no" strategy is actually a *preferable* public policy, since it avoids the administrative costs of fair hearing procedures to raise the CSRA, or the legal costs of obtaining court orders to raise

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[21] [21]Prior to the enactment of the Medicaid spousal impoverishment provisions, only the assets of the institutionalized spouse were deemed available in determining Medicaid eligibility beyond the first full month of institutionalization. Thus, prior to MCCA, the financial circumstances of the community spouse were highly dependent upon in whose name the financial assets of the married couple were held. If all of the married couple's assets were in the name of the institutionalized spouse, the community spouse could be left with nothing, but if all of the assets were in the name of the community spouse, no assets belonging to the community spouse had to be spent down prior to obtaining Medicaid for the institutionalized spouse (beyond the first month of institutionalization).

the CSRA.[22] To the authors, it is indeed somewhat curious why Congress included the explicit provision cited above, and the Committee Report includes no explanatory language about it.

The use of the "just say no" strategy was rampant in some counties. Eligibility workers in the urban counties (Monroe, New York City, Nassau, and Suffolk) indicated that *virtually every long-term care application involving a community spouse* employed the "just say no" strategy. Eligibility workers in the three rural counties reported that the use of the technique was sometimes used, but was not widespread, presumably because applicants were not as aware of the option and had not consulted attorneys prior to making application. The policy impact of the "just say no" strategy must be fully realized: *it essentially eliminates means-testing of Medicaid nursing home benefits for persons who still have a living spouse at the time of nursing home admission.*

Another reason for the widespread use of the spousal refusal approach in New York is the ease with which it can be accomplished. In Suffolk county, for example, upon receipt of a long-term care application, DSS sent a letter to the community spouse informing him or her of their rights and responsibilities for supporting the care of the institutionalized spouse. If the available resources of the couple were above the state CSRA level (which was $72,660 in 1994), the letter informed the spouse on the amount of resources that had to be contributed to the institutionalized spouse's care before eligibility will be granted. However, the same letter also informed the community spouse of the option to refuse to contribute resources to the care of the community spouse, and allowed the community spouse to indicate their refusal simply by checking a box. Furthermore, the letter stated that if the community spouse did not respond at all, that the county would assume that the community spouse was refusing to comply and was not providing support.

State Medicaid officials indicated that this policy in Suffolk County of informing the community spouse of his or her rights to refuse to provide financial support was done pursuant to a pre-spousal impoverishment court order (Brill v. Perales) which required the state to provide such notice to the spouse in the community. However, with the implementation of the MCCA spousal impoverishment provisions, the use of this form has since been discontinued in Suffolk County.

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[22] [22]See, for example, Koldin, Stephen. "'Spousal Refusal' in New York State," *The ElderLaw Report*, Vol. VI, No. 9, April 1995. Koldin writes: "In New York State, the spousal refusal option accomplishes an important public policy objective: avoiding litigation."

In other counties, eligibility workers showed us similar forms that had been drawn up by advocacy organizations and elder law attorneys which simply provided documentation of the community spouse's refusal to support the institutionalized spouse. These forms only required the community spouse to check a box indicating his or her refusal to provide a support, and to add his or her signature. Eligibility workers reported that under state law, they were required to accept such forms as sufficient documentation of spousal abandonment, and to approve Medicaid eligibility for the institutionalized spouse.

If a community spouse indicates a refusal to support the institutionalized spouse, or does not respond to the letter at all, an assignment of support letter is drawn up by the Medicaid Department and signed by the institutionalized spouse (if able) which allows the state to proceed against the *excess* resources (those resources in excess of statutory limits) of the community spouse for the cost of nursing home care provided to the institutionalized spouse by Medicaid. However, state officials reported that approximately 95 percent of applicants in community spouse cases *already have* an assignment of support letter when they apply for Medicaid, along with the documentation of spousal refusal.

Theoretically, the assignment of support letter gives the county the legal authority to pursue the community spouse for failing to provide financial support to the institutionalized spouse. However, in all of the counties we visited, DSS attorneys indicated that legal actions were rarely taken against a community spouse for failing to provide financial support to the institutionalized spouse. DSS attorneys stated that they were overwhelmed with other DSS-related legal issues that were of higher priority, such as child abuse and abandonment cases, and besides, they were generally pessimistic about the likelihood of making successful recoveries from community spouses if such cases were pursued. DSS legal staff believed that the courts would likely rule in favor of the right of the community spouse to refuse support if such cases were litigated.

Although the "just say no" strategy was the most widely used technique to preserve assets for a community spouse, local workers reported that some applicants instead employed the strategy of using the fair hearing process to raise the CSRA level in order to bring the community spouse's MMMNA allowance up to the allowable amount of $1,817 per month. Presumably, this strategy is used by some couples who prefer *not* to create a situation where the local DSS district has the authority to pursue the community spouse for financial support, even if there is little real threat of the local DSS office taking such action.

Penalty Periods for Multiple Transfers

Eligibility workers reported that in past years, the use of multiple transfers to create concurrent penalty periods was a relatively common phenomenon. OBRA '93 clarified that when Medicaid applicants have made multiple transfers during the look-back period (now 36 months prior to the date of application) the penalty period is to be calculated by summing the total amount of all transfers made. However, even prior to the enactment of OBRA '93, New York DSS had issued an Administrative Directive in October 1992 changing the method of calculating penalty periods for multiple transfers, so that OBRA '93 merely provided stronger statutory justification for New York's administrative directive.[23] Eligibility workers reported that this was a welcome change, since the prior method of applying concurrent penalty periods allowed applicants to transfer significant assets without incurring any delay in Medicaid eligibility.

Workers also reported relatively high use of the "half a loaf" method as a method for transferring assets among non-married applicants. Elder law attorneys in New York appeared to be universally knowledgeable of the "half a loaf" strategy and employed this strategy liberally. Local DSS offices use regional "private pay" rates to compute the penalty period for identified asset transfers, and since the private cost of nursing home care is very high in some areas of New York, particularly in the New York City metropolitan area, more assets can be transferred in New York under the "half a loaf" method than in other states. For example, if the private cost of nursing home care is $5,000 per month, prospective Medicaid applicants can transfer up to $5,000 per month in the pre-application period without incurring a penalty period after they apply.

Transfers to Qualify for Home Care Services

In addition to high spending rates for Medicaid-covered nursing home care, New York also has very high Medicaid expenditures for home care services. In FY 1994, New York spent over $1.8 billion for Medicaid-financed personal care services, accounting for 62 percent of total Medicaid spending for personal care services nationwide. In 1993, about 88,000 Medicaid enrollees received personal care

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[23] [23]New York DSS Administrative Directive: *Transfer of Resources: Changes in the Method of Calculating Transfer Penalty Periods*. 92 ADM-44, October 28, 1992.

services, and each recipient of personal care services averaged 139 hours of personal care services per month (about 32 hours per week).[24]

The Medicare Catastrophic Coverage Act also changed SSI and Medicaid eligibility policy by *eliminating* transfer of asset penalties for SSI eligibility, and Medicaid eligibility *other than* eligibility for long-term care services. The rationale for this change was that there is little incentive for individuals to transfer all of their wealth simply to receive an SSI check of about $440 per month (or less, depending upon the amount of Social Security income also received) or to receive Medicaid-covered services other than long-term care, and because the application of transfer of asset rules for SSI applicants was administratively burdensome for the Social Security Administration.

Although there may be little incentive for elderly persons to transfer assets to qualify for Medicaid benefits other than long-term care benefits, the generous coverage of home care services in New York's Medicaid program creates a larger incentive in New York. In 1993, the average recipient of personal care services in New York received an annual equivalent of $16,000 in services.[25] Thus, elder law attorneys reported that another Medicaid estate planning strategy was to have their clients transfer all of their assets, apply for Medicaid home care services, and "hang on" as long as possible before applying for nursing home admission. The longer a client could be maintained in the community through the use of home care services, the more assets could be protected under the "half a loaf" method.

Since transfer of asset penalties are applied once recipients of home care services enter nursing homes, DSS maintains records of applicants of home care services who have transferred assets prior to Medicaid application (in the event that applicants subsequently enter nursing homes). In the six month period from October 1993 through March 1994, local DSS offices reported an average of 28 home care applicants per month who had transferred all of their assets in the pre-application period.

Largely a result of lobbying efforts by the New York state delegation, Congress included a provision in OBRA '93 allowing states, at their option, to apply transfer of asset penalties on transfers made for the purpose of qualifying for Medicaid-covered home care services. However, after the

[24]Personal communication, New York State Department of Social Services, July 1994.

[25]The actual value would be higher in the private home care market, and additional value is received through coverage of other Medicaid services, such as prescription drugs.

enactment of OBRA '93, the New York state legislature failed to enact this provision into state law, and has still not done so at the time of this writing.

Use of Trusts

DSS officials, elder law attorneys and local eligibility workers all reported that Medicaid trusts were used relatively infrequently as a Medicaid planning device in New York. The infrequent use of trusts relates to the fact that other Medicaid planning strategies, such as the "just say no" strategy, were equally or more effective strategies for preserving assets, and were also less costly in terms of the attorney fees required to implement the strategy.

Furthermore, elder law attorneys and eligibility workers reported that this was an area where a lot of "bad" Medicaid planning was occurring. They reported that in many cases attorneys with little or no expertise in Medicaid eligibility policy were writing trusts for clients that offerred no protection of trust assets and/or income from being counted as available resources in the event of subsequent application for Medicaid.

One type of trust that had been used in prior years as a Medicaid planning device was the so-called "trigger trust." Trigger trusts include language which give the trustee discretion to distribute trust principal or income as he or she so chooses *until such time* the settlor applies for Medicaid or enters a nursing home, at which time the trustee's discretion to distribute income or principal is terminated, with all subsequent distributions from the trust becoming non-discretionary. The purpose of trigger trusts was to prevent the assets of the trust from being deemed available as a countable resource under Medicaid eligibility rules *in the event* the settlor of the trust required nursing home care. However, in 1992, the New York legislature amended its Estate, Powers and Trust Law to render such provisions in any trust instrument void.

Although OBRA '93 provided further statutory authority to limit trusts as a Medicaid planning device, DSS had not issued implementing regulations at the time of our site visit in May of 1994. In any case, since trusts were not perceived as a common Medicaid planning tool prior to OBRA '93 in New York, DSS did not anticipate that the OBRA '93 trust provisions would have much of an additional effect.

Estate Recovery Programs in New York

Estate recovery in New York is a highly decentralized process. Each local DSS district is responsible for operating its own estate recovery program, and local districts are given broad leeway in their organizational approach to estate recovery. In many districts, estate recovery activities are a subset of each district's third party liability functions, and there are often not local DSS staff who are exclusively dedicated to estate recovery functions. In addition, estate recovery functions usually fall under the overall administrative jurisdiction of the local DSS general counsel, who has a broad range of responsibilities of which estate recovery activities are only a small part. Even in the reporting of local DSS districts to the state DSS office, the reporting of dollars recovered through estate recovery are often not disaggregated from funds recovered through other third party liability, so that the state does not even have good data on the amount of money recovered by local districts from estate recovery efforts.

As in other states, estate recovery in New York generally involves the following process:

- The local DSS district identifies Medicaid recipients over the age of 65 who have recently died. The state DSS reported that the larger DSS districts use computerized matches to identify deaths while many of the smaller districts simply follow the local obituary columns.
- The district determines whether there is a surviving relative that would preclude the placement of a claim against the decedent's estate. This information is usually obtained from the deceased Medicaid recipient's case record.
- The district establishes the amount of Medicaid payments made on behalf of the Medicaid recipient since his or her 65th birthday. Local districts reported considerable problems obtaining these data, which often require a six to eight week turnaround. The inability to obtain data on the potential amount of the claim limits the local districts' ability to pursue estate recoveries in a timely manner.
- The DSS district files a lien against the estate of the deceased Medicaid recipient in the appropriate surrogate court.
- Local districts attempt to ascertain the value of assets held in the estates of deceased Medicaid recipients, and pursue those cases where there is the greatest likelihood of making recovery.

Local DSS attorneys interviewed during the site visit indicated that estate recovery efforts in New York are highly litigious. Attorneys representing the heirs of a Medicaid recipient's estate frequently contest the claim of DSS against the estate. DSS legal staff also reported that the local courts often rule in favor of the heirs against DSS. Since local judges are elected officials, DSS attorneys claimed that decisions in favor of heirs were often politically motivated.

In addition, local DSS offices indicated that they had little financial incentive to pursue estate recoveries. Local county taxes pay for 10 percent of all Medicaid long-term care costs, so that the

county only receives ten cents back on every dollar recovered. Forty cents of every dollar recovered goes to the state, and fifty cents goes back to the Federal government. However, local DSS districts are required to pay 50 percent of the state share of administrative costs, or 25 percent of the total cost. Thus, local DSS offices reported that estate recovery activities, in many instances, are money "losers," meaning that it costs the county government more to pursue estate recoveries than it gets back from the recoveries it makes.

Consequently, although New York does not have good data on funds returned through estate recovery efforts, it was generally felt that estate recovery efforts in the state are not particularly effective, and could be improved substantially. For example, if one assumes that New York City accounts for half of all spending for nursing homes (1990 data from DSS indicates that NYC accounted for 52 percent of all nursing spending in that year), in 1993, NYC DSS recovered 0.4 percent of Medicaid nursing home payments through estate recovery. In contrast, the state of Oregon recovered 2.5 percent of its Medicaid payments for nursing home care in 1993, or six times the rate recovered by New York City.[26]

The state had implemented a lien program in 1992 to protect the state's claim against the real property held by Medicaid nursing home recipients in the event of sale or transfer of the property prior to death. A survey conducted by the state in October of 1993 indicated that 3,334 liens were filed by local DSS districts in 1992.

Local DSS district staff interviewed during the site visit were generally supportive of the idea of centralizing estate recovery functions in Albany, particularly for the small districts that have few administrative resources to devote to estate recovery activities. Some local districts had also hired attorneys (ex-DSS attorneys with strong track records in estate recovery) on a contingency basis rather than pursue recoveries themselves. The state was also providing guidance to local DSS districts on the methods which districts could use in contracting for estate recovery services with private entities on a contingency basis.

Since Medicaid estate planning strategies are widespread in New York, and very effective in protecting assets for community spouses, the state DSS and local districts were interested in the

[26]New York City DSS attorneys estimated total estate recoveries in 1993 of $9.0 million. Data for estate recoveries in Oregon obtained from Department of Health and Human Services Office of Inspector General report, "Medicaid Estate Recovery Programs," October 1994 (draft).

possibility of pursuing estate recoveries from the estates of surviving spouses upon their subsequent death. While pursuing recoveries from the estates of surviving spouses was allowed under state law in New York, most counties indicated they did *not* pursue legal action was because they felt that their chances of winning cases were very slim. In so claiming, DSS attorneys cited a 1993 court case (***Matter of Estate of Craig***) which they believed limited the chances of their winning a suit against a community spouse for failing to support an institutionalized spouse.[27]

The ***Craig*** case involved a situation in which a county had attempted to recover from the estate of a spouse for Medicaid costs incurred by her predeceased husband. The crux of the case centered on the definition of "responsible relative," since under New York state Social Services Law, an "implied contract" for reimbursement for services provided to a medical assistance recipient is only applicable to responsible relatives. In the ***Craig*** case, the appeals court defined a responsible relative as one who has sufficient ability to pay for the Medicaid recipient's expenses at the time that expenses were incurred, and since Mrs. Craig did not have sufficient ability to pay at the time her husband was receiving Medicaid, the state could not recover from her estate after her death.

State Medicaid officials and local DSS estate recovery staff believed that the ***Craig*** case served as a significant barrier to recovering from the estates of surviving spouses. Also, since the state is precluded under Federal law from filing liens on the property of surviving spouses, there is nothing to prevent surviving spouses from transferring all or most of their assets to heirs prior to death in order to avoid recovery (unless the surviving spouse also applies for Medicaid at some future point).

Impacts of OBRA '93 and Recent Legislative Initiatives

State Medicaid officials felt that OBRA '93 would probably have little effect on Medicaid estate planning in New York. New York had already implemented policies to treat multiple transfers concurrently, had limited the use of trigger trusts, and already had an estate recovery program in effect. Although trusts had not been used frequently as a Medicaid planning device, DSS felt that the trusts provisions of OBRA '93 would reduce the use of trusts even further, and the elder law attorneys we talked to agreed with this prediction.

Since the site visit to New York was conducted, there has been a change in administration as a result of the gubernatorial election of November 1994. State Medicaid officials believed that the new

[27] ***Matter of Estate of Craig*** 604 N.Y.S. 2d 908 (Ct. App. 1993).

political climate would improve chances for the enactment of legislation to tighten up eligibility policies to achieve Medicaid program savings. The Administration developed legislation to (a) address the "just say no" strategy, (b) apply transfer of asset penalties to home and community-based care recipients (c) expand the scope of allowable recovery efforts to include property outside the probated estate, and to allow recoveries against the estates of responsible relatives, and (d) to reduce the minimum Community Spouse Resource Allowance. However, in July of 1995, all of the Administration's proposed changes were rejected, and the legislature chose to instead achieve Medicaid program savings in long-term care through cuts in provider reimbursements.

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